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Case study on case management for children orphaned or made vulnerable by HIV (OVC)

# FROM ASSESSMENT TO GRADUATION: COMPREHENSIVE CASE MANAGEMENT FOR VULNERABLE CHILDREN AND HOUSEHOLDS

## The SCORE Project In Uganda

*This publication is made possible by the generous support of the American people through the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the United States Agency for International Development (USAID) under cooperative agreement AID-OAA-A-14-00061. The contents are the responsibility of the Coordinating Comprehensive Care for Children (4Children) project and do not necessarily reflect the views of USAID or the United States Government.*

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## Acknowledgements

This case study would not have been possible without the incredible support of the SCORE project team. The well-organized agenda and accompaniment to the field facilitated an excellent learning and documentation process. The team has been incredibly generous with their time, continuing to share information, answer questions, and update the 4Children team long after the initial scoping visit.


People for development

Appreciation also goes to the caregivers, project officers, community legal volunteers, district and sub-county community development officers, and various implementing partners, who gave their time and stories. It is our sincere hope that 4Children has been able to capture your important work through this case study.

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## Acronyms

| | |
|---|---|
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **ART** | Antiretroviral Therapy |
| **AVSI** | Asociación de Voluntarios Para El Servicio Internacional |
| **CARE** | Cooperative for Assistance and Relief Everywhere |
| **CBT** | Community-based Trainer |
| **CBF** | Community-based Facilitator |
| **CBSD** | Community Based Services Department |
| **CDO** | Community Development Officer |
| **CFPU** | Child and Family Protection Unit of the Uganda Police |
| **CFS** | Child Friendly Schools |
| **CLV** | Community Legal Volunteers |
| **CSI** | Child Status Index |
| **DEOs** | District Education Officers |
| **DOP** | District Operational Plan |
| **DOVCC** | District Orphans and Vulnerable Children Coordination Committee |
| **EPRC** | Economic Policy Research Center |
| **FFS** | Farmer Field School |
| **FHI 360** | Family Health International |
| **FGD** | Focus Group Discussion |
| **HCT** | HIV Counseling and Testing |
| **HH** | Household |
| **IP** | Implementing Partner |
| **KII** | Key Informant Interview |
| **MGLSD** | Ministry of Gender, Labour and Social Development |
| **MoH** | Ministry of Health |
| **NAT** | Needs Assessment Tool |
| **NPE** | Nutrition Peer Educators |
| **NSPPI** | National Strategic Program Plan of Interventions |
| **OVC** | Orphans and Vulnerable Children |
| **PEPFAR** | U.S. President's Emergency Plan for AIDS Relief |
| **STA** | Senior Technical Advisor |
| **STAR-EC** | Strengthening Tuberculosis and Acquired Immunodeficiency Syndrome in East Central region |
| **SUNRISE-OVC** | Strengthening Uganda's National Response for Implementation of Services for Orphans and Other Vulnerable Children |
| **TOT** | Trainer of Trainers |
| **TPO** | Transcultural Psychosocial Organization |
| **TSA** | The Salvation Army |
| **UGX** | Uganda Shillings |
| **VAT** | Vulnerability Assessment Tool |
| **VCD** | Value Chain Development |
| **VHT** | Village Health Team |
| **VSLA** | Village Savings and Loans Association |

# Glossary of Terms

**Community Legal Volunteers:** Community Legal Volunteers (CLVs) are members of the community trained to support children's access to legal services and to monitor child protection violations in the community. They receive training in child protection from SCORE staff with support from FIDA-Uganda (The Uganda Association of Women Lawyers). The approach is intended to proactively prevent rights violations and build community capabilities to use the law to solve day-to-day legal disputes, helping children and families to access the formal justice system as needed.

**Community Development Officer:** Working at the Sub-County level, the Community Development Officer (CDO) is the government representative responsible for the planning, budgeting, monitoring, and implementation of development programs at the community level, as well as the primary linkage to social welfare services at the community level. They are responsible for sensitizing the community on legislation on gender and child rights.

**Probation and Social Welfare Officer:** The Probation and Social Welfare Officer (PSWO) is the legal representative for children and families in the justice system, responsible for domestic violence cases, children in conflict with the law, and child abuse cases reported within the district.

**SCORE Steering Committee:** The SCORE project is overseen by six steering committee members, including one senior technical advisor focusing on each of the four project objectives—socio-economic strengthening, food security and nutrition, child protection and legal services, and family strengthening—as well as a senior strategic information advisor, and the project's director. The Steering Committee guides the technical implementation of the project, and provides supportive supervision at the partner and community levels.

## Objectives of the case study

The overall objective of the case study is to highlight and help promote good practice related to case management within orphans and vulnerable children (OVC) programming. The case study illustrates the core components of a case management system (see Figure 1), the positive results of a case management system, and some of the challenges in developing, implementing, and solidifying a case management system within an OVC program. The information presented should be understood as just one example of a case management system in practice. Any case management system should be adapted to best reflect the context where it is utilized, the target population it serves, and the programmatic needs of the implementer. The case study is one in a series of case studies highlighting different aspects of a case management system utilized by OVC programs and national child protection systems. The purpose of the case studies is to provide useful information that can inform the work of policy makers and practitioners who aim to effectively support vulnerable children and families.

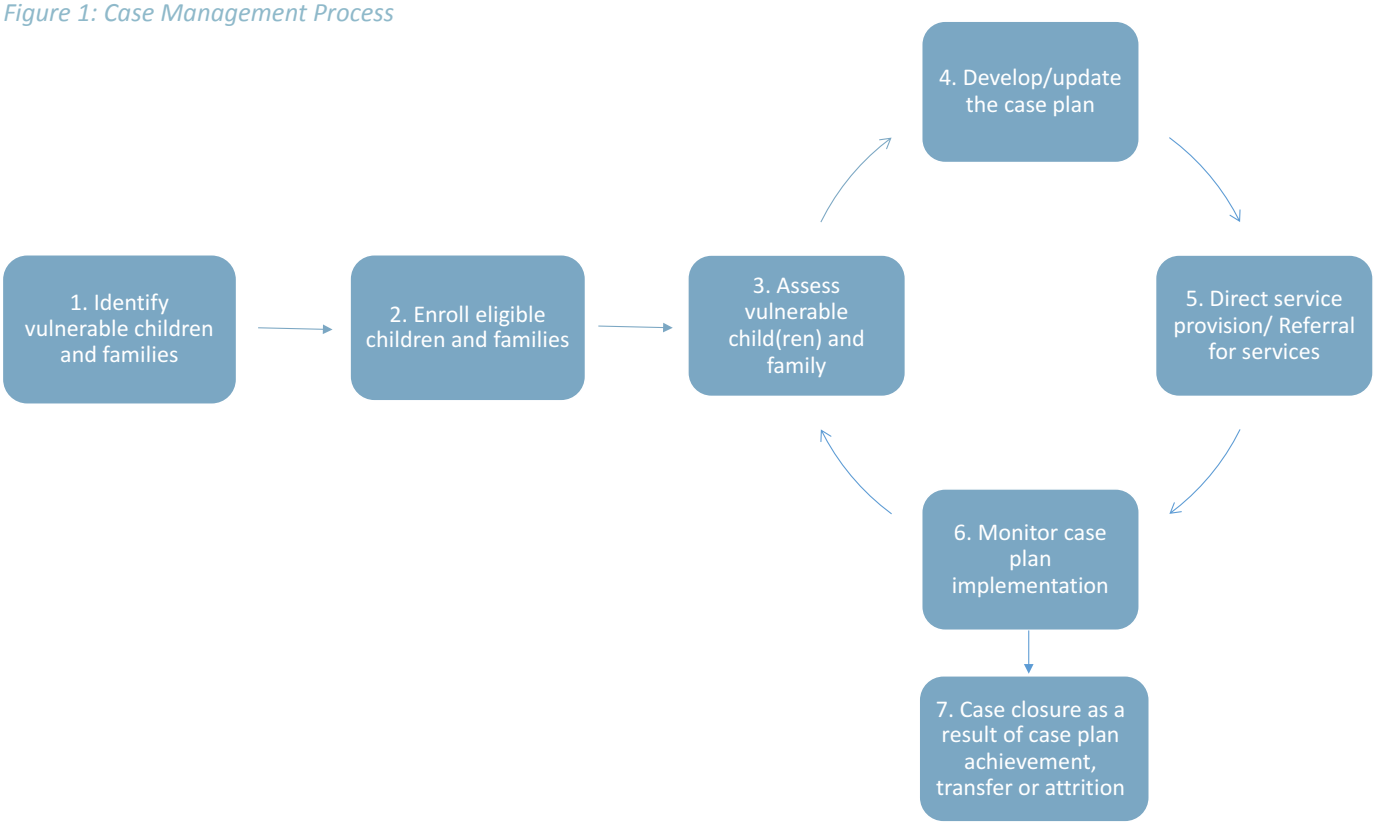
The information used to inform this case study was collected during a desk review of relevant project documents and through key informant interviews (KII) and focus group discussions (FGD) conducted during a field visit to Uganda in December 2015. In total, 26 documents were included in the desk review and discussions were held with 48 people representing program management staff working with the Sustainable Comprehensive Responses for Vulnerable Children and their Families (SCORE) project, national- and district-level government, civil society organizations (CSOs), community-based facilitators, and trainers, volunteers, and caregivers. This process was not intended as an assessment, but rather as an opportunity to see a case management system in action, speak with those responsible for specific components of the case management system, and hear the voices of those who are served by the case management system. The following case study describes the case management system developed by SCORE.

## Country overview

### POVERTY AND CHILD VULNERABILITY IN UGANDA

While progress has been made to improve well-being and realization of the rights of children in Uganda over the last two decades, a large number of children remain vulnerable to abuse, exploitation, and violence. These include 4.4 million children living in poverty, 2.2 million orphans, 310,000 child-headed households, 40,000 children living in childcare institutions, 10,000 children living on the streets with no adult care, 500,000 children involved in hazardous work, children murdered through ritual practices, and children in servitude.[1] In total, over 8 million children, or 51% of the total child population, are moderately (43%) or critically vulnerable (8%). Many of Uganda's children still face abuse and neglect despite the existence of an elaborate legal and policy framework for the protection of children.[2] The health status of children in Uganda remains poor as reflected in the unmet Millennium Development Goals (MDG) and government targets. Neo-natal mortality is at 27 per 1,000 live births; infant mortality is at 54 per 1,000; and under-five mortality is at 90 per 1,000 live births. Malaria remains the leading cause of death among

*Figure 1: Case Management Process*




1 Walakira, E.J., D. Muhangi, S. Munyuwiny, F. Matovu, E. Awich, I. Ddumba Nyanzi, J. Kayiwa, J. Akellot, P. Mubiri, J. Majugo, A. Mutebi, M. Ruiz-Rodriguez 2016. The State of the Ugandan Child—An Analytical Overview. https://swsa.mak.ac.ug/sites/default/files/docs/Analysis-of-the-State-of-Ugandan-Child-Final-Final-%20Final.pdf

2 UNICEF and MGLSD. (2015) Situation Analysis of Children in Uganda. http://www.unicef.org/uganda/UNICEF_SitAn_7_2015_(Full_report).pdf

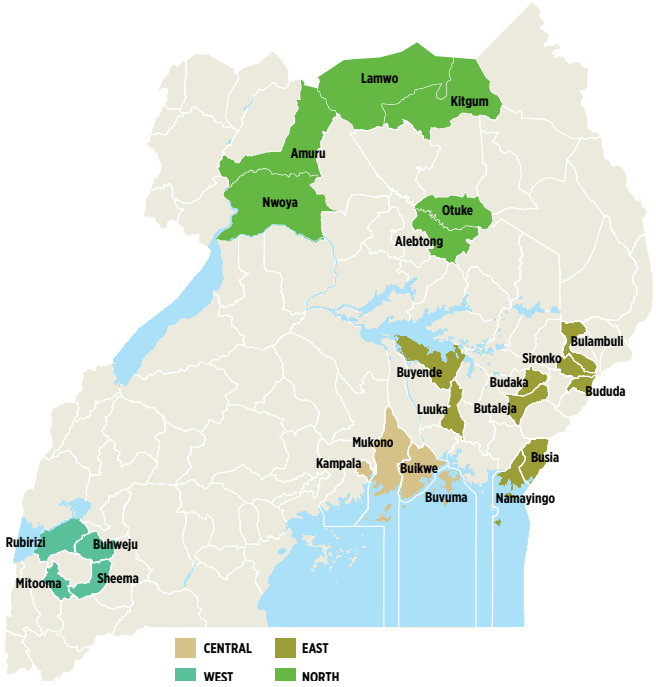
children under five, accounting for almost 28.8% of the deaths. Malnutrition persists with one in every three children (an estimated 2 million children) stunted.[3]

Pediatric HIV prevention and treatment remain a challenge, and while HIV prevalence has declined overall, an estimated 147,394 children 0-14 years of age are living with HIV. HIV prevalence among children 10-14 years of age stands at 1.9% for males and 2.3% for females, and among young people aged 15-24 years, HIV prevalence increased from 2.9% in 2004-05 to 3.7% in 2011.[4] Likewise, the number of AIDS-related deaths in children aged 0–4 years decreased by more than 50% from 100,000 between 2000 and 2012, while deaths in adolescents increased from less than 50,000 to over 100,000 between 2000 and 2012 (UNICEF, 2013). Per the Uganda AIDS Commission, 34% of those who want AIDS support services are not able to access them due to fear of stigma and discrimination, delays in receipt of services, and challenges getting to health facilities.[5] The intersection of violence and HIV is indisputable. Women who have experienced violence are up to three times more likely to become infected with HIV than those who have not, and over time partner violence increases the risk for HIV infection among women and girls by more than 50 percent. There is increasing evidence that child protection violations increase the risk of acquiring HIV and that children affected by HIV are at increased risk of exposure to violence.[6]

## THE SOCIAL SERVICE SYSTEM IN UGANDA

Child protection and social welfare issues fall under the mandate of the Ministry of Gender, Labour and Social Development (MGLSD) at the national level and the Community Based Services Department (CBSD) at the district level while HIV prevention and treatment is under the mandate of the Ministry of Health (MoH). The Government of Uganda recently passed the Children's (Amendment) Bill 2015, which seeks to strengthen the protection of children's rights. The Children's Amendment restricts legal guardianship of children to Ugandan citizens, regulates inter-country adoption, prohibits corporal punishment, and prevents all forms of child exploitation, providing a legal framework for the child protection work under the MGLSD.[7] In addition, the MGLSD is in the process of revising and disseminating an evolving suite of tools, policies, and protocols to improve case management. They are also rolling out a series of trainings on updated protocols for OVC-MIS, the on-line tool for tracking service delivery. MGLSD is planning to validate a national protocol for graduation in the first week of January 2017 with support from MEASURE, after collecting input from key partners and pre-testing in three districts, with plans to disseminate following full approval. These efforts have led to slow, but notable change, in spite of chronic underfunding of the social welfare sector in Uganda, which averages just 0.5% of the national budget for the MGLSD and 1.4% of the local government budget for the CBSD.[8] To fulfill its mandate within the existing budget constraints, the MGLSD works closely with implementing partners funded by USAID and other donors to ensure their programs align closely with government policy and plans, and to guide service provision for OVC and their families at the local level.

*Figure 2: SCORE coverage by District (2016)[9]*




## THE SCORE PROJECT

The SCORE Project is implemented by a four-partner consortium led by AVSI Foundation, CARE, TPO Uganda (Transcultural Psychosocial Organization), and FHI 360, and runs from April 2011 to April 2018. Working in close collaboration with over 45 local civil society organizations (CSOs) that serve as implementing partners embedded in communities, SCORE started in 35 districts in Uganda and was operational in 23 of those districts as of December 2016.[9] The project implements interventions at both the community and household (HH) levels. SCORE targets 25,000 HHs and 125,000 vulnerable children and caregivers affected by HIV and AIDS as direct/enrolled beneficiaries, but reaches close to double that number through community-based and group interventions that are open to all community members (including members of both enrolled and non-enrolled HHs).[10] The four strategic objective areas addressed by SCORE include: 1) socio-economic strengthening, 2) food security and nutrition, 3) child protection and legal services, and 4) family strengthening.

3 Walakira, E.J. et al (2016). The State of the Ugandan Child—An Analytical Overview.
4 UNICEF and MGLSD (2015). Situation Analysis of Children in Uganda.
5 Ibid.
6 UNAIDS (2010). Women, Girls and HIV Fact sheet.
7 Republic of Uganda, Children (Amendment) Act (2016).
8 Ministry of Gender, Labour and Social Development (2011). Issues Paper Strengthening Human Resources and Financing for Child Care and Protection Services.
9 The SCORE project started in 35 districts and is currently active in 23 (as of October 2015). The reduction occurred in September 2015 (last month of year 4) when the project transitioned 12 districts to new OVC mechanisms (the Better Outcomes for Children and Youth [BOCY] and Sustainable Outcomes for Children and Youth [SOCY] projects). See figure 2 on page 3 for SCORE coverage by District. http://score.or.ug/maps/
10 SCORE rigorously tracks the direct beneficiary households, but does not assign codes to non-beneficiary households and risks double-counting reporting official outreach numbers. SCORE reports on households reached by quarter, and estimates that about the same number as the direct households attend SCORE activities.

SCORE builds the capacity of the household to produce and market nutritious foods and to practice good hygiene.

Photo by SCORE

Staffing structures, roles, and responsibilities are organized by the four objective areas at senior management, implementing partner (IP), and community levels. Although IP staff titles vary (project officers, coordinators, etc.), most partner staff are social service workers with varying qualifications and additional training provided by SCORE in the technical areas of the SCORE interventions. All project officers, irrespective of sector, are responsible for family case management and trained on the SCORE Program Guidelines. Case management within the SCORE project includes targeting and identification of OVC and their families in coordination with district government, assessment of potential beneficiaries' needs and resources available, enrollment, joint development of a family case plan, referral to appropriate multi-sectoral services, case plan monitoring and follow-up, and the closure of case files when families achieve a degree of self-sufficiency and "graduate" from the program.

In addition, in order to foster coordination with existing child protection mechanisms and recognized pathways, all project officers working with children and families are required to attend a nationally recognized child protection training[11] developed by TPO Uganda and facilitated by Makerere University staff to help them to understand child protection principles and how to apply them in their work. The training covers the laws governing child and family rights in Uganda, as well as international standards for child protection programming. The training ensures that staff are familiar with legal and policy frameworks and structures in Uganda, and take appropriate steps to address child protection violations to refer and manage cases within the statutory case management system for child protection.

Project officers also manage the implementation of project activities within their respective areas of expertise (one of the four SCORE objective areas). The SCORE project coordinates regular project officer meetings in which case files are discussed and actions developed, supporting peer-to-peer coordination and learning. In addition, senior technical staff employed by SCORE visit IPs each quarter, and accompany project officers on visits to the community to observe technical interventions. Project officers, in turn, spend an average of four workdays each week in communities supporting community volunteers, accompanying them on home visits, and monitoring community-based interventions.[12]

## SCORE Family Case Management and Graduation Model

From the outset, the SCORE project envisioned a household[13] case management approach that facilitates enrolled households/clients to progress out of extreme vulnerability and "graduate" from direct project support once they achieve self-sufficiency. The concept of graduation, commonly used within poverty reduction programming is also referred to within OVC programming as case plan achievement. Case plan achievement is broadly understood as the point at which a child and family can meet their basic needs and the pre-determined benchmarks in the areas of safety, stability, education, and health, and no longer require the interventions offered by an OVC program. Because the SCORE project described this process as graduation rather than case plan achievement during the implementation of this project, the term graduation will be used throughout this case study. The graduation approach became the SCORE Case Management and Graduation model. At enrollment, households are assessed using a *Vulnerability Assessment Tool (VAT)* to identify areas in which they are vulnerable and may need additional support. The same tool is used to monitor progress toward graduation, ensuring use of consistent indicators to measure eligibility, vulnerability, progress, and graduation throughout the project cycle and across implementing partners. Although IPs appreciated the consistency of measurement, some acknowledged that that indicators for eligibility enrollment were not necessarily appropriate for assessing readiness to graduate.

### IDENTIFICATION

To identify vulnerable households, SCORE partner staff referred to lists of vulnerable households previously mapped in coordination with district officials, community members, and CSOs.[14] These lists of vulnerable households were initially created with the support of the SUNRISE-OVC project using a participatory rural appraisal methodology.[15] SCORE estimated that approximately 85% of mapped households met SCORE enrollment criteria.[16] The lists offered a useful place to start the process of identification. However, the lists have limitations. For example,

11 http://www.cpcnetwork.org/wp-content/uploads/2014/04/Child-Protection-Manual_Final20120301.pdf

12 Community volunteers/outreach workers have different titles and compensation based on their objective area and responsibilities; these include community-based trainers, community-based facilitators, nutrition peer educators, and community legal volunteers.

13 Household in this case is similar to a family in other OVC programs, i.e., the child(ren) and caregiver(s) living together.

14 The VAT does not include a pre-assessment/identification tool. The Ugandan government, in coordination with USAID's MEASURE Evaluation project, recently developed a new tool, the Household Vulnerability Prioritization Tool (HVPT) that allows projects to prioritize households based on the specific types and aspects of vulnerability presenting the greatest risk to children prior to carrying out a more comprehensive assessment using a tool such as the VAT. Although SCORE has acknowledged the utility to the HVPT, SCORE decided to continue using the VAT to identify new households to ensure consistency.

15 Under the SUNRISE-OVC project, district officials, often the DCDO and PSWO, worked alongside project staff to conduct a community mapping exercise using a participatory rural appraisal methodology in 72 districts, 680 sub-counties, and 4,200 parishes (representing 64% national coverage), and identified 1.5 million vulnerable children.

16 KII Rita Larok, Chief of Party AVSI/SCORE; interview date: 8.17.15.

Households may be identified through HIV testing and services for enrollment in SCORE.

Photo by SCORE

vulnerability is not fixed. The lists provided a one-time snap shot of vulnerability within districts. For this reason, the lists of mapped households were supplemented by meetings with local leaders and CBOs and visits to the communities to identify additional vulnerable households not included in original lists. SCORE has also scaled up efforts to identify households through care and treatment facilities, in addition to on-going community identification processes, to ensure the project is reaching HIV-affected households.

## ASSESSMENT

After identification, the IP project officer visits households considered to be potentially eligible for services under the SCORE project to conduct an assessment using the *Vulnerability Assessment Tool (VAT)* described previously.[17] The VAT is a tool developed by the SCORE project to assesses vulnerability under the project's four objective areas: economic wellbeing, food security and nutrition, child protection and legal services, including HIV status, and family strengthening. Several project officers noted that household members were not always honest during the first assessment: they weren't willing to disclose confidential information, such as their HIV status, and most did not disclose their real income, exaggerating their vulnerability in hopes of accessing more resources.[18] Despite these challenges, the comprehensive nature of the VAT tool, combined with observation, helped program staff to assess the household status. They also indicated that as they could build trust with families as the project progressed, families became more honest in their responses.[19] Within the SCORE project, the VAT is conducted at enrollment and at least once per year throughout the project to monitor household progression and assess eligibility for graduation. While the VAT is comprehensive in design and provides vulnerability data across key programming indicators, it does not include an assessment of individual children within the household. In addition, the use of an aggregate score to determine eligibility can make it difficult for the project to identify and respond to specific or individual vulnerabilities, such as child protection risks, and may leave out vulnerable children living in households that score below the threshold for eligibility. The project manages these risks by leaving space for the assessor to score the household based on their impression of the perceived needs and vulnerabilities of the family, beyond the scored questions in the VAT tool.

## ENROLLMENT

To be enrolled in the SCORE project, a household must score above the enrollment threshold of 40 points on the VAT.[20] Households scoring between 40 and 53 are considered "moderately vulnerable," and households with a VAT score 54 or above are considered "critically vulnerable." Households scoring below 40 are excluded from direct enrollment, i.e., they are not tracked or directly served by the project, but are still welcome to participate in SCORE community and group activities as indirect beneficiaries. Once a household is determined eligible for the project, the local implementing partner opens a case file for that household, and creates a *unique identifier code* to protect their identity and ensure confidentiality and to track their participation in SCORE activities.[21] Due to widespread vulnerability, many partner organizations quickly reached the enrollment threshold, and found it difficult to respond to the needs of vulnerable children and households identified at a later date due to limited capacity to support to non-enrolled households reached through community and group interventions. However, where child protection concerns were identified, even if the child was an indirect beneficiary, the project supported response and assistance to the child and household.

## CREATION OF A HOUSEHOLD DEVELOPMENT PLAN

Following the completion of the VAT, if the household is determined to be vulnerable and eligible for the SCORE project, the IP project officer visiting the household then registers household members and conducts a needs assessment using the *Needs Assessment Tool (NAT).* The NAT collects data on the household location and the names, ages, birth registration, HIV status, employment, and education of each household member, as well as on awareness of and access to critical services and barriers to access. The Household Development Plan, page two of the NAT, includes a form for each household head to rank their priorities across the four technical areas of intervention and list the commitments of both the household and project to address these needs (e.g., if SCORE is arranging an apprenticeship for an unemployed youth in the household, SCORE commits to covering the apprenticeship fee and arranging the program, while the household commits to providing transport and lunch for the youth). This process helps to communicate to the household: "*We recognize that you have needs, but you also have capacities.*"[22] Project officers felt that the NAT helped the household to identify and build on their

17 The VAT and all SCORE case management tools are published on OVCSupport.org.

18 FGD, project officers, The Kampala Group/SCORE; interview date: 12.4.15.

19 FGD, project officers, St. Francis Clinic, interview date: 12.3.15. KII Kezia Nabalayo, Regional Program Coordinator, The Salvation Army; interview date: 12.7.15.

20 Initially HIV-positive status did not result in automatic enrollment within the SCORE project, but was included in the VAT, along with other markers that increase the vulnerability score, such as orphanhood. Later in the project, HIV-affected households were prioritized for enrollment.

21 Households that do not meet SCORE eligibility criteria are able to participate in SCORE group activities, although they do not receive individual home visits, monitoring or referral support.

22 KII Rita Larok, Chief of Party, AVSI/SCORE; interview date: 8.17.15.

strengths, but noted that households frequently participate in different and/or additional activities than those initially identified in the NAT due to evolving needs and priorities. The lack of a household record of the plan was cited as a missed opportunity by several project officers who recommended that future projects leave a copy of the plan with each household for future visits since the original NAT is retained by staff for project records.[23] Some partners did distribute home visit books in which the project officer could record what they discussed and key actions for the family.

## IMPLEMENTATION OF THE CASE PLAN

***Project-supported services***. The majority of SCORE activities are organized through groups that are open to both enrolled and non-beneficiary households. These activities include, but are not limited to: Village Savings and Loans Associations (VSLAs), financial education, financial and insurance linkages, Selection Planning and Management (SPM) training for small businesses[24], apprenticeships for out-of-school youth, Farmer Field Schools, nutrition training, activities to create child-friendly schools, child protection training, community dialogues, psycho-social activities, parenting and life skills training, birth registration, child protection response services, legal support, and HIV testing and counseling services. While most of these activities are led by IP project officers and community volunteers, some activities, such as birth registration, child protection response services, legal support, and HIV testing and counseling services, rely on collaboration with other service providers. The project relies on a robust monitoring and evaluation system to track household participation in SCORE activities via unique tracking codes, allowing the project to track how closely a given household is following their development plan, and the impact of SCORE activities on household vulnerability outcomes. This data is managed at the project level and accessible to IP staff, though there is currently no feedback mechanism to share plans, progress, or outcomes back to the households or for households to monitor and report on their own progress and accomplishments.

***Referrals to non-project supported services.*** SCORE relies on a strong network of service providers who are not directly supported by the project to address household needs beyond the project scope. At the start of the project, implementing partner staff in each catchment area were tasked to identify and map other service providers and develop Memorandums of Understanding (MOUs) formalizing partnership with the project. This process ensured that SCORE staff were familiar with the services available and the requirements to access services, and that households referred by SCORE for services would not be turned away. These partnerships were identified by all SCORE staff as key to the project's success: **"***If you look at the budget we have, and the outputs we have, the impact is bigger than the project. We couldn't have done it without linkages."*[25]

Referrals to external service providers are tracked through the use of *triplicate carbon copy referral forms* specifically designed for the SCORE project.[26] At the time of referral, two copies are given to the client, while another copy remains with the staff initiating the referral. The referring IP project officer then enters details of the referral in the *referral log* at the office. When the client presents for services, he gives both copies of the referral form to the service provider. The service provider notes any critical information about the service provided and any test outcomes or recommendations for follow-up actions/services. One copy of the referral form is left with the service provider, while the other copy is given to the client to return to the office of the referring organization (e.g., SCORE). SCORE adds the form to the household file, and enters the results of the service and the date the service was provided in the referral log. Later the monitoring and evaluation (M&E) officer enters this information into both the project database and OVC MIS, the government database developed by the MGLSD.

If the referral form is not returned within the expected time frame, as is often the case, the referring IP project officer visits the household to confirm if the referral was successful. If the household has not completed the referral, the project officer documents the challenges and develops a plan to address the challenge, assessing the need for additional support. Staff acknowledged that the project-specific referral forms created additional paperwork for health clinics, duplicating the record-keeping required by the Ministry of Health, and there was some resistance to filling out the forms. In addition, although the referral system is robust, it relies on intensive follow-up by project officers to complete. Since the start of the project, SCORE officers have referred 11,343 household members for critical services, and referred and supported HIV testing for 28,536 people. At the start of the project, 71,402 individuals (63% of all household members enrolled in the project) did not know their HIV status. At the time this case study was developed, this number had been reduced by 40% to 42,866 individuals (38.2% of the members of enrolled households). Referrals were higher at the start of the project, reflective of a declining need for referrals during the later years of the project as households' resilience increased and household members were better able to directly access referral points.[27]

***Supported referrals.*** While the SCORE Program Guidelines specifically advise against accompanying the client to the service point to minimize dependency, SCORE does occasionally provide transport and financial support to cover the cost of accessing a service in the case of a medical emergency or extreme poverty. Partners are expected to inform the project Steering Committee of all cases where additional direct support is required. However, they are also given the flexibility to respond to immediate needs without waiting for approval. Staff at IPs acknowledged that while

23 FGD, project officers, The Kampala Group; interview date: 12.4.15.

24 The Selection, Planning and Management training is designed by CARE to support field agents teach VSLA members to: 1. Select an IGA that is appropriate for their household, after assessing the skills and financial capacity of household members. 2. Plan the startup of the IGA. 3. Manage the IGA's risks and cash flow. http://www.seepnetwork.org/iga-selection--planning-and-management-for-village-agents--va--resources-1140.php

25 KII Rita Larok, COP AVSI/SCORE Project; interview date: 12.1.15.

26 MGLSD and the MoH each have their own referral mechanisms and paperwork. The SCORE project collaborates with and provides referrals to services managed by both ministries, but uses project-developed forms to track referrals.

27 KII Rita Larok, email: 6.28.16.

Community sensitization prior to campaigns to promote HIV testing and services is credited with addressing stigma and other barriers to disclosure.

Photo by SCORE

the ability to provide direct support was minimal, they had worked with their supervisors to secure additional support to address acute medical or child protection needs. As the Regional Program Coordinator for the Salvation Army explained, "*If a child has a problem, we write to AVSI as we are working. We don't leave the child there, we move. We had a case where a child had broken his leg and the parents told us too late. When we reached there, the child was in a sorry state. We collected the child and brought him to the hospital. We have the family emergency funds, we paid all the bills. We saved a life.*"[28]

***Community clinics and aggregated referrals.*** When staff identified a high demand for a specific service, they worked with service providers to bring the service to the communities. This enabled the project to introduce new services and service providers to the community, to reduce travel expenses for community members, and to dramatically increase the number of households accessing core services, such as HIV testing and counseling, birth registration and legal advice. Services are generally provided through community-wide events that are not limited to SCORE enrolled households. However, SCORE households that require specific services are provided a referral form prior to the event, enabling the project to track their access to services within the formal referral system and to record outcomes. For example, the referral form for HTC services requests test results. The project follows up with all clients who test HIV negative to advise them on ways to stay HIV negative. If clients test HIV positive, the project provides further referrals to HIV treatment and counseling (HTC) and supports adherence through regular home visits and monitoring. The intensive community sensitization prior to HTC campaigns, provision of personal referral forms, and relationship between the project staff and the household help to address barriers to disclosure. Staff are also trained on positive and timely disclosure of adult and pediatric HIV, and support households with disclosure during their home visit counseling.

## MONITORING AND FOLLOW-UP

SCORE households receive regular home visits from project officers approximately once per quarter, and from community volunteers at a greater frequency. The frequency of home visits varies depending on the needs of the household, and some high-need households receive up to six visits per quarter. Each project officer has an average of 55 households assigned to him/her for case management, including home visits and referral monitoring. These households are also supported by cadres of other workers at community level, including nutrition peer educators, village health teams, community legal volunteers, para-social workers, and farmer field school facilitators (among others). Individual household coding and regular data reviews enable IPs to track how frequently project staff visit enrolled households, and identify and prioritize those households that were not visited in a previous quarter. The project officer's dual responsibilities as household case managers and activity/intervention officers make it difficult to conduct formal home visits with more frequency. This is a concern for extremely vulnerable households where increased home visitation might be beneficial.

Project officer visits are tracked using a comprehensive home visit form, the SCORE Reporting Tool for Home Visits. The form includes basic household details such as location and name of household head. It also serves as an interim follow-up and needs assessment, collecting information about the reason for the current visit, findings, actions/services provided and actions for follow up, applicable key issues discussed during the visit, and the name, age, and school attendance of all school-aged children in the household, as well as coded data on HIV treatment and adherence for known HIV-positive household members. The form also includes a review of the psychosocial and health status of the Index child, considered the most vulnerable in the household, asking questions about the following psychosocial indicators: presence of a supportive caregiver, relationship of the child and caregiver, behavior of the child, and child's emotional state/mood.

In addition to regular home visits, households are reassessed every 12-24 months using the Vulnerability Assessment Tool (VAT), the same tool used for enrollment. If the VAT score is above 40, the household continues to be a direct beneficiary as they are considered to be in a state of vulnerability. If, at a follow-up assessment, a household's VAT returns a score below the enrollment threshold, the household is considered to be in a state of *pre-graduation*. The project continues to monitor the household for another year to ensure the improved household well-being status is maintained. At a subsequent assessment, a pre-graduated household's VAT score may "bounce back" above the enrollment threshold. This suggests the improvement was only temporary, and the household should continue to receive support under the SCORE project.[29] Following each application of the VAT, the project officer is expected to complete a new needs assessment and household development plan, but these new documents were often poorly filled out or left blank in

28 KII Kezia Nabalayo, Regional Program Coordinator, The Salvation Army, interview date: 12.7.15.
29 USAID, AVSI, CARE, TPO, FHI 360. SCORE Graduation Model (handout).

A family that consistently scores well on the household's vulnerability assessment tool can be considered stable and ready to graduate from the program.

Photo by SCORE

the records, suggesting this was not a priority for staff or the households, possibly due to paperwork fatigue.

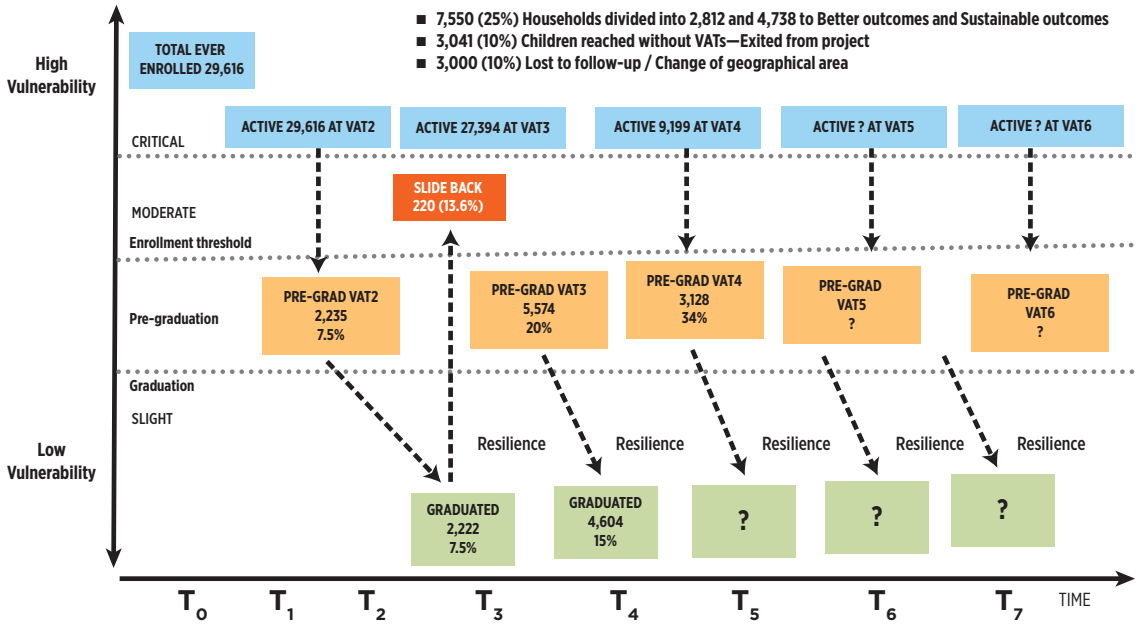
## GRADUATION

Once a household scores below 40 on two consecutive assessments over a 24-month period, the household is considered to be stable and ready to graduate from direct project support. The IP project officer working with the household organizes a ceremony for the household and other graduating households in coordination with local leadership to celebrate their achievements. At the graduation ceremony, household members share their testimony and accomplishments, and encourage other households to continue working to achieve their goals. For project officers with implementing partners, graduation is a major achievement and an end objective of their work.[30] After the ceremony, the case file for the household is officially closed. Closed case files are moved to a separate location within the filing system (or marked as closed if electronic), but kept for project records. Households are followed for one year following graduation to ascertain if they maintain their graduation status or not. If households indicate new vulnerabilities, there is a possibility for reenrollment or assistance in response to crises, as is provided to other indirect beneficiary households.

By using the same metrics for enrollment and graduation, SCORE focuses staff and clients on the goal of graduation from the beginning of their involvement in the project. Following graduation from the program, the household may continue participating in on-going community-based activities and groups that are open to non-enrolled households, but no additional Household Development Plans will be created for these households and they no longer receive regular home visits. The project may enroll a new household in its place. While this is a transparent approach to graduation and worked well within the SCORE project, using the same criteria for enrollment and graduation is no longer considered best practice. Graduation criteria is now expected to be more rigorous, and to reflect the achievement of project objectives and improvements in OVC well-being.

Staff acknowledge that vulnerability is not static, and households remain vulnerable to shocks such as the death of a household head or drought or other event affecting the household's income generation. While most felt the project's interventions had an impact, they acknowledged that many households remained on the verge of vulnerability. Many felt strongly that graduated households should be monitored and supported for an additional year following graduation. To better understand the stability of graduated households,

*Figure 3: SCORE Graduation Model*




30 FGD, St. Francis Clinic project officers; interview date: 12.4.15

SCORE is conducting cohort and tracer studies with enrolled beneficiaries, and is continuing to collect and update files for a subset of graduated households within the project.

The SCORE project has been extended into 2018, but is closing in several districts. Within those districts many beneficiary households remain vulnerable, and will not meet the criteria to graduate within the project's time frame. They must instead be transferred to another source of support, either to a new project and/or to the government social welfare office, prior to the close of the project. Several IPs are in the process of transferring their remaining caseloads to new projects, physically sharing case files or electronic data with the new partner. IPs without a new project in their catchment area are transferring caseloads to the Community Based Services Department (CBSD) in the district, with the expectation that the district will provide some follow-up and transfer cases to any new CSOs or projects entering the district.

## COORDINATION WITH OTHER CASE MANAGEMENT SYSTEMS

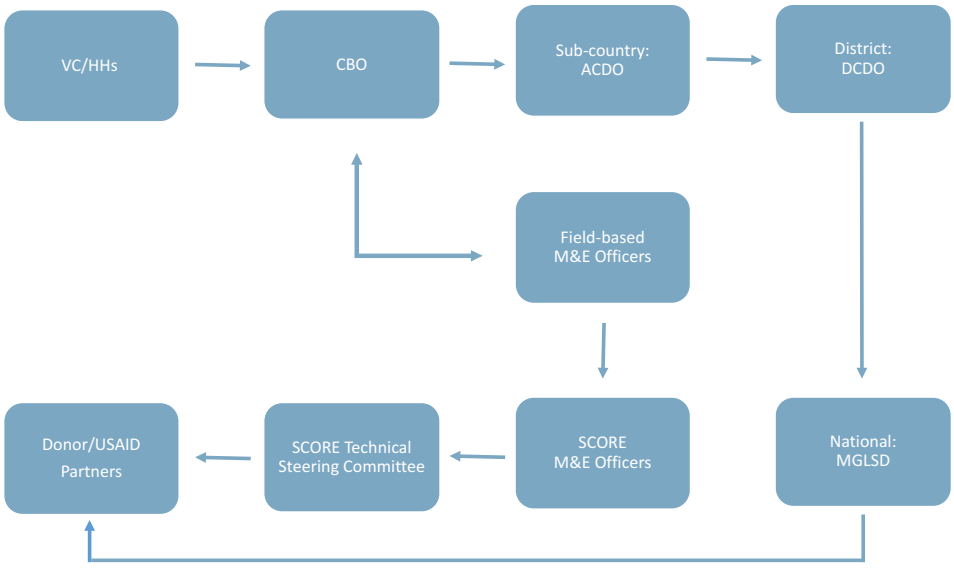
While the project has a developed specialized process for household case management, the project follows the national Ministry of Health and Ministry of Gender, Labor and Social Development guidelines for managing individual malnutrition and child protection cases.

***Case management for malnutrition.*** SCORE follows the national Integrated Management of Acute Malnutrition (IMAM) Guidelines developed by the Ministry of Health with support from UNICEF to manage child malnutrition cases. The project officer responsible for food security and nutrition works closely with nutrition peer educators, VHTs, and local health clinics to sensitize the community, identify and screen potential malnutrition cases, refer cases for the provision of therapeutic food, and provide follow-up visits to the household to monitor cases. Case management is supplemented by household food security and nutrition interventions to build the capacity of the household to produce and market nutritional food, provide nutritionally balanced meals, and practice good hygiene.[31]

***Case management for child protection.*** Child protection cases may be identified either by trained community members who are part of local child protection mechanisms or by SCORE staff. SCORE, with technical support from the Uganda Association of Women Lawyers (FIDA-Uganda), trained a cohort of community legal volunteers (CLVs) from each community to support children's access to legal and justice services and monitor child protection violations in their community. The approach is intended to proactively prevent rights violations, build community capabilities to use the law to solve day-to-day legal disputes, and help them to access the formal justice system when needed. CLVs are required to fill out a simplified case report for all identified cases of child abuse, including the child's individual/household code to protect confidentiality and an overview of the case, action recommended and action taken, and actions for follow-up. In cases of more severe incidents of abuse or when the violation cannot be resolved in the community, the child protection project officer is involved. The project officer completes the more detailed UNICEF Intake and Assessment Form and accompanies the child to the police. With the involvement of the Probation and Social Welfare Officer (PSWO) and the Community Development Officer (CDO), the case is brought to the Magistrate in court for adjudication.[32]

In districts or sub-counties where child protection actors meet for monthly case conferencing, SCORE staff meet with government and other non-state child protection actors to discuss the child protection cases they have identified that month, share successes, and troubleshoot difficult cases.

*Figure 4: Flow of monitoring data*




31 KII Dr. Francis Obita, Food Security and Nutrition Technical Advisor; interview date: 12.1.15.
32 KII Kezia Nabalayo, Regional Program Coordinator, The Salvation Army; interview date: 12.7.15.

SCORE also organizes Community Outreach/Legal Clinics, which bring the police or PSWO to the community to sensitize community members on legal issues relevant to them, sensitize the community to reporting processes, and address minor legal concerns on site.

### DATA COLLECTION, STORAGE AND USE

***Data collection.*** The SCORE project has a rigorous data collection and management process in place. At the time of enrollment, every household and individual household member is given an individual identifier, which is used to track their participation in all activities and all services received throughout the duration of the project. Project staff collect detailed data during the implementation of activities using the following general data collection tools: Vulnerability Assessment Tool, Needs Assessment Tool, Household Development Plan, Activity Group Form (for all trainings), Home Visit Form, Referral, Referral Log, and the OVC MIS data collection tool. These are supplemented by specialized data collection forms for the activities conducted under each objective area. This allows the project to track activity-specific metrics, including total savings and lending activities by members of VSLA groups, nutritional screening details of individuals and households, and a tailored case management and referral form for community legal volunteers and child protection cases, which also allows the project to track sector-specific data, as well as general participation and outcomes. Project staff recognize the value of data collection, but admit that documentation processes are intensive and often tedious and burdensome for both staff and clients. The SCORE data collection process is intensive by all accounts, and some clients became frustrated with the quantity and repetition of the data forms and requirements. Many staff indicated that having fewer and simpler forms might have reduced the paperwork burden for staff, volunteers, and households alike.

***Managing case files and confidentiality.*** Prior to engaging with households, all SCORE project officers sign a consent form promising to keep personal information and any data collection forms confidential. The SCORE project manages household data through both a digital database and through a traditional filing system at each IP office. Each implementing partner stores the primary data collection tools and VAT, NAT, and Household Development Plans in case files organized by household. The forms are stored under lock and key and close supervision to ensure confidentiality, but are accessible to the project staff.

***Digital data entry and use*.** Staff transfer the field data collection forms tailored to data entry forms at the end of each work day, or when they have time in the office. Each implementing partner has an M&E officer responsible for data entry in both the SCORE database and OVCMIS. While the M&E officer is often more focused on reporting and data review, he or she receives additional training and support to run queries and analyze data with their teams.

> "*We sit together with them, we go through their data together and we analyze: What did we do with the households that moved? Which did not move? When we sat in those meetings, people were shocked at their own data and what they found. They had not been visiting a certain place. It's the first time people put it together. Data use should be standardized at the lowest level.*"[33]

SCORE project leadership and steering committee advisors are particularly interested in understanding vulnerability, which activities are working, what household factors affect vulnerability, and how households transition out of poverty. The team analyzed the data collected throughout the project along with more detailed individual household data from a smaller cohort of 2,200 households to examine questions of vulnerability and program impact. The team has drafted papers on the following topics: assessing the determinants of vulnerability, assessing determinants of school enrollment and absenteeism,[34] the effectiveness of the SCORE project at addressing the drivers of family separation, and operational assessments of core programming activities: community legal volunteers, youth life skills training,[35] parenting training,[36] and savings groups. This operational research is conducted by the senior technical advisory group under the leadership of the strategic information advisor, and is shared with IP staff.

## Conclusion: Case Management and the Human Perspective

Each member of the SCORE project staff independently shared an appreciation for the clear and coherent project guidelines and case management system. However, they were equally quick to admit that the system itself is not directly responsive to individual needs, and is reliant on the judgment and care of project staff. As Strategic Information Advisor Patrick Walugembe explained:

"*Regardless of the robust vulnerability assessments and all other assessments, vulnerability itself is such a complex phenomenon that even the most robust system may not necessarily pick out the most vulnerable. For instance, if the assessment looks at shelter, child protection parameters, etc., all may be good, but it still can fail to pick one single child who is at risk of dying the next day due to severe malnourishing complications. In such cases, we have to rely on human intuition, putting aside all the set parameters and make subjective decisions. We cannot separate the process from human perspective*."[37]

Other staff echoed this sentiment in their words and actions. Project officers carefully document success stories, and photos of children and caregivers are posted on the partner office walls. The office of Salvation Army Regional Coordinator Kezia Nabalayo had pictures of several individual children she had supported, including a child who had an emergency amputation and recovered, a child who needed regular blood transfusions, and one child the project didn't reach in time, a

33 KII Patrick Walugembe, SCORE Strategic Information Advisor, FHI 360; interview: 12.2.15.

34 Not all of the research is published. Some are manuscripts submitted to conferences, others are about to be published, while still others may be found on the SCORE website as a link to a presentation.

35 http://54.67.71.236/score/uploads/USAID_%20SCORE_Life_%20skills_training%20impacts_on_%20Resilience_%20of_Youth_REPPSSI%20-.pdf

36 http://54.67.71.236/score/uploads/SCORE%20Parenting%20Operations%20Research%20Report.pdf

37 KII Patrick Walugembe, SCORE Strategic Information Advisor, FHI 360; interview date: 12.2.15.

constant reminder of the unique vulnerability of an individual child.[38] While the case management system employed by SCORE provides guidelines to identify, enroll, and systematically support vulnerable households and children, at the end of the day, addressing multiple types of vulnerability and responding to individual and household needs remain a very human process—relying on the commitment of the household members themselves, the judgement and responsiveness of individual staff members, and the flexibility of program leadership to adjust the response within the project's resources and scope, a fact that SCORE staff at all levels seem to understand.

38 KII Kezia Nabalayo, Regional Program Coordinator, The Salvation Army; interview date: 12.7.15.

# Annexes

## Annex 1: Documents reviewed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## Annex 2: Key informant interviews

| NR | NAME | TITLE | ORGANIZATION | DATE |
|---|---|---|---|---|
| 1. | Rita Larok | COP | AVSI/SCORE | 12.1.15 |
| 2. | Jordan Canocakacon | SCORE Project Manager | AVSI/SCORE | 12.1.15 |
| 3. | Rebecca Nyonyozi | TA, Economic Strengthening | CARE/SCORE | 12.2.15 |
| 4. | Thomas Kamusimme | TA, Child Protection and Legal | TPO/SCORE | 12.2.15 |
| 5. | Alfred Agaba | TA, Family Strengthening | AVSI/SCORE | 12.2.15 |
| 6. | Patrick Walugembe | TA, Strategic Information | FHI 360/SCORE | 12.2.15 |
| 7. | Dr. Francis Obita | TA, Food Security and Nutrition | AVSI/SCORE | 12.3.15 |
| 8. | John Paul Nyeko | M&E Coordinator | AVSI/SCORE | 12.4.15 |
| 9. | Charles Ddamlira | Program Assistant | Kampala Group | 12.4.15 |
| 10. | Alice Mbewaali | Project Officer | Kampala Group | 12.4.15 |
| 11. | Janet Namalike Wepukhulu | Program Assistant | Kampala Group | 12.4.15 |
| 12. | Rwanda Gerald | Program Assistant | Kampala Group | 12.4.15 |
| 13. | Emily Namanya | Data Officer | Kampala Group | 12.4.15 |
| 14. | Frango Ogutu | Accounts Assistant | Kampala Group | 12.4.15 |
| 15. | Joseph Mtuli | Team Lead | St. Francis Health Center/SCORE IP | 12.3.15 |
| 16. | Maurice Antonio | Project Officer | St. Francis | 12.3.15 |
| 17. | Kacu Binta Flavia | Project Officer | St. Francis | 12.3.15 |
| 18. | Muiza Grace | Project Officer | St. Francis | 12.3.15 |
| 19. | Mr. James Kabogoza | Commissioner | MGLSD | 12.4.15 |
| 20. | Lydia Wasula | OVC Coordinator | MGLSD | 12.4.15 |
| 21. | Ismael Ddumba-Nyanzi | Consultant | Makarere University | 12.5.15 |
| 22. | Kezia Nabalayo | Regional Program Coordinator | Salvation Army | 12.7.15 |
| 23. | Nathan Khuakha | Program Coordinator | Salvation Army | 12.7.15 |
| 24. | Agnes Mutonyu | Program Coordinator | Salvation Army | 12.7.15 |
| 25. | Daniel Robert Khisa | Assistant Program Coordinator | Salvation Army | 12.7.15 |
| 26. | Misanga Medi Kasanjja | Program Coordinator | Salvation Army | 12.7.15 |
| 27. | Patrick Wassike | Program Coordinator | Salvation Army | 12.7.15 |
| 28. | Doreen Nayadoi | Program Coordinator | Salvation Army | 12.7.15 |
| 29. | Nekesa Phelice | Assistant Program Coordinator | Salvation Army | 12.7.15 |
| 30. | David Tsolobi | District Community Development Officer | Bududa District | 12.7.15 |
| 31. | Beatrice Wakoli | Senior Probation and Welfare Officer | Bududa District | 12.7.15 |
| 32. | Daniel Wangobi | Husband, Caregiver | Busai Parish | 12.8.15 |
| 33. | Florence Nambia | Wife, Caregiver | Busai Parish | 12.8.15 |
| 34. | Kutosi Jafis | Community Legal Volunteer | Budaka Sub-county | 12.8.15 |
| 35. | Teresa Wozmati | Teacher, Community-Based Facilitator | Madula Sub-county | 12.8.15 |
| 36. | Matia Kbosho | Project Officer & Accountant, Community-Based Trainer | | 12.8.15 |

| NR | NAME | TITLE | ORGANIZATION | DATE |
|---|---|---|---|---|
| 37. | Samuel Wakoli | Community-Based Facilitator | Wakuma Parish | 12.8.15 |
| 38. | Lidia Wachila | Community-Based Trainer | Wakuma Parish | 12.8.15 |
| 39. | Florence Wahota | Community-Based Trainer | Budaka Sub-County | 12.8.15 |
| 40. | Godfrey Cheboko | Community-Based Trainer | | 12.8.15 |
| 41. | Idina Mushikora | Community-Legal Volunteer/Community-Based Facilitator | | 12.8.15 |
| 42. | Fred Womono | Community Volunteer | Wahata Parish | 12.8.15 |
| 43. | Michael Walua | Community Legal Volunteer | | 12.8.15 |
| 44. | Lule Rashid | Community Legal Volunteer | | 12.8.15 |
| 45. | Robina | Mother, Caregiver | Wichivino Parish | 12.8.15 |
| 46. | Sarah | Widow | Ussai Parish | 12.8.15 |
| 47. | Florence Ayo | Capacity Building Technical Advisor | CRS/Sustainable Outcomes for OVC | 12.10.15 |

*Coordinating Comprehensive Care for Children (4Children) is a five-year (2014-2019), USAID-funded project to improve health and well-being outcomes for Orphans and Vulnerable Children (OVC) affected by HIV and AIDS and other adversities. The project aims to assist OVC by building technical and organizational capacity, strengthening essential components of the social service system, and improving linkages with health and other sectors. The project is implemented through a consortium led by Catholic Relief Services (CRS) with partners IntraHealth International, Pact, Plan International USA, Maestral International, and Westat.*