Guidance for PEPFAR Orphans and Vulnerable Children (OVC) Implementing Partners

GOOD PRACTICES IN CASE MANAGEMENT

HOW YOUR OVC PROGRAM CAN BE READY FOR A SITE IMPROVEMENT MONITORING SYSTEM (SIMS) ASSESSMENT

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Acknowledgements

List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome	**NGO**	Non-Governmental Organization
ART	Antiretroviral Therapy	**OVC**	Orphans and Vulnerable Children
CDC	Centers for Disease Control and Prevention	**PEPFAR**	U.S. President's Emergency Plan for AIDS Relief
CEE	Core Essential Element	**PLHIV**	People Living with HIV
CP	Child Protection	**PMTCT**	Prevention of Mother to Child Transmission
CRS	Catholic Relief Services	**PSS**	Psychosocial Support
ECD	Early Childhood Development	**SIMS**	Site Improvement Monitoring System
HES	Household Economic Strengthening	**USAID**	United States Agency for International Development
HIV	Human Immunodeficiency Virus		
HTC	HIV Testing and Counselling	**USG**	United States Government
IP	Implementing Partner		

Introduction

The Site Improvement Monitoring System (SIMS) is an important part of the U.S. Government's efforts to strengthen the quality of services delivered to people affected by HIV. Assessments of PEPFAR-funded OVC programs using the SIMS Community Tool are being carried out in order to ensure that these programs are meeting minimum standards and providing quality services to OVC and their families.

This guide has been written in order to assist OVC program personnel to understand key terms and concepts used in the SIMS Community Tool, specifically the section on case management services for OVC. It is intended to help ensure that OVC program implementers understand the standards and the requirements outlined in the SIMS case management Core Essential Element (CEE). But it also aims to more broadly outline best practices in OVC programming and provide practical guidance in setting up systems and delivering services that will improve the quality of care provided to vulnerable children and their families.

A variety of tools, forms, and other resources are provided. Because these tools were developed for a specific context, they should always be carefully reviewed and adapted to make sure that they are appropriate for a new context in which they might be used. Similarly, because practices are constantly changing and improving as the HIV and child protection sector evolves, it is expected that this guidance will need to be updated frequently. In this sense, the guide and its contents should be considered a "living document."

If you have comments or questions on the guide, or if you have resources your program is using which could benefit others, please share them with the 4Children project so that they can be included in future versions.

Case Management Services

A. INTRODUCTION

PEPFAR's Orphans and Vulnerable Children (OVC) programming delivers child-focused, family-centered interventions that seek to improve well-being and mitigate the impact of HIV and AIDS on children and families. This effort involves working in partnership with children and families to identify, plan, and complete a series of actions in an effort to achieve specific goals. This process is typically referred to as case management.

> In the context of OVC programs, case management can be understood as the process of **identifying** vulnerable children and families; **assessing** their needs and resources; working together to establish specific, realistic objectives and goals and **planning** actions to achieve objectives and goals; **implementing** plans through completing specific actions and receiving services; **monitoring** both the completion of actions (including the receipt of services in a timely, context-sensitive, individualized, and family-centered manner) and progress toward achievement of objectives/goals (e.g., child protection and well-being, including HIV prevention, treatment, and adherence).

B. PRINCIPLES OF EFFECTIVE CASE MANAGEMENT

While case management systems will vary depending on the context, effective case management generally adheres to a few core principles, listed below. These principles encourage case managers[1] to:

- Promote collaboration and partnership with the "client unit," generally a family or household, including a child or children and their caregivers;

- Use a strengths-based approach, which identifies and builds on a client's strengths, resources, agency, and potential contributions to efforts to improve client's own well-being and protection, rather than a pathology-based approach, which focuses exclusively on the needs of or problems faced by the client;

- Whenever possible, facilitate self-determination and self-care through advocacy, shared problem-solving, decision-making, and education;

- Recognize that the strengths and vulnerabilities associated with children and families are multi-faceted, and seek to enhance coordination and integration among different sectors (e.g., health/HIV, education, child protection, and social welfare), while at the same time helping clients to navigate multiple services and reducing gaps in services;

- Integrate approaches and interventions aligned to the ages and development stages of children;

- Promote client safety and ensure that standardized operating procedures are in place for addressing emergencies should client experience them (e.g., domestic violence, child abuse, neglect, exploitation, or severe malnutrition);

- Promote the integration of behavioral change science and principles;

- Practice cultural competence, including awareness and respect for diversity;

- Promote the use of evidence-based care and interventions;

- Pursue professional excellence and maintain competence and confidentiality in practice;

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1   A case manager (also referred to as a case worker or social service worker) may be a community volunteer or member of a community-based organization (CBO), non-governmental organization (NGO), or government body.

- Use a goal-oriented approach, promote quality outcomes, and pursue measurement of those outcomes;

- Support and maintain compliance with national, local, and organizational policies, workforce standards, and certification rules and regulations related to case management.

C. CASE MANAGEMENT — CRITICAL STEPS

There are seven core steps in the case management process which are highlighted below in Figure 1.

1. IDENTIFICATION

> → **Definition:** A process of identifying children orphaned, affected or made vulnerable by HIV and AIDS and other adversities and their caregivers, and referring them for further eligibility verification and assessment.
>
> ✓ **Priority Actions:** Establish and document procedures for identifying orphans and vulnerable children through multiple entry points, and referring them for screening and program enrollment.

The number of children who are potential beneficiaries of United States Government (USG) assistance is usually higher than the number who can be served, when considering the resources available. PEPFAR intends its programs to reach "children who have lost a parent to HIV/AIDS, who are otherwise directly affected by the disease, or who live in areas of high HIV prevalence and may be vulnerable to the disease or its socioeconomic effects."[3]

The table below includes key OVC subpopulations who should be prioritized for needs assessment to determine their eligibility for program enrollment (other groups, such as young mothers or children living with disabilities who are affected by HIV, may be added, depending on OU/SNU context, epidemiological data, and priorities). The key entry points for identification are also indicated.
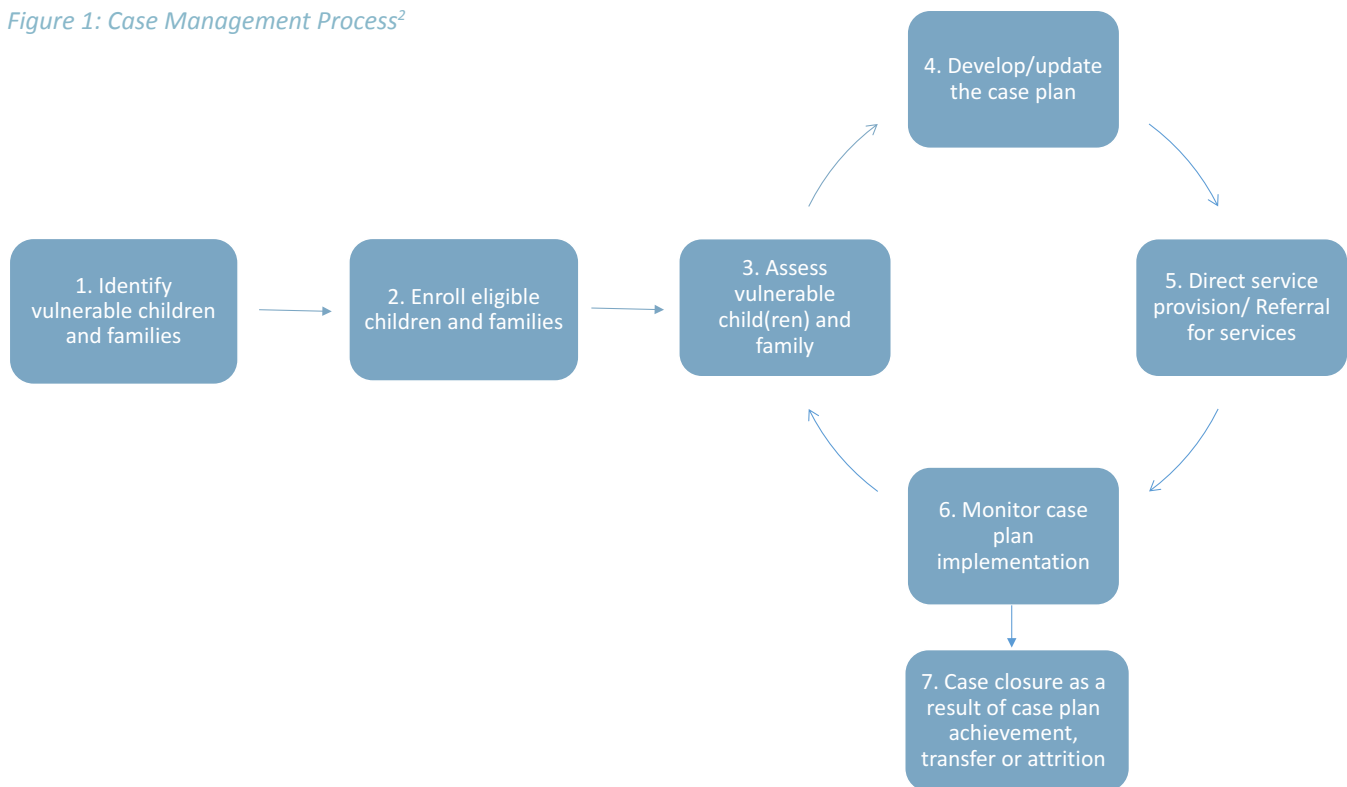
The processes used to identify and refer children and their caregivers to OVC programs through these entry points should be documented (written); functional, fair, and transparent; understood and agreed to by all involved in the identification and referral process, and, where possible, by other key stakeholders; and followed consistently. Having standard procedures, intake tools, and forms, etc., will help to ensure fair and impartial criteria are used to identify appropriate clients, rapidly assess their vulnerability, and determine if their cases would be appropriate for and benefit from enrollment in an OVC program.

RESOURCES:

- 4Children (2017). Case Management in Orphans and Vulnerable Children Programming.

- 4Children (2017). Summary of Key Findings from the 4Children Case Management Case Studies.

- 2016 Operational Considerations for Strengthened Targeting in PEPFAR OVC Programs

Please see additional resources at the bottom of the following page.

Figure 1: Case Management Process[2]

SUBPOPULATION	KEY ENTRY POINTS FOR IDENTIFICATION
Children & adolescents living with HIV	Primary entry points: • Clinical service providers serving HIV-positive children enrolled in care or on treatment in priority SNUs. • Community-based groups such as "mother to mother" and PLHIV support groups with tracing of their children.
Children & adolescents who have lost one or both parents in high-HIV-burden areas	Primary entry points: • Community-based identification by CSOs, including child protection committees, traditional leaders/structures, women's and/or faith-based groups, etc., as well as referrals from ministries of social welfare/affairs Secondary entry points: • Peer-support groups: adolescents as caregivers and child-headed household support groups • Adolescent treatment support groups • Institutional care (orphanages) • Review of data provided by ministries of social welfare/development, if available and reliable
Infants (<2 years) exposed to HIV	Primary entry points: • Clinical HIV care and treatment services for adults, children, and PMTCT services • Mother-to-mother support groups specifically targeting HIV+ mothers/pregnant and breastfeeding women, and/or adolescents living with HIV support groups (as many adolescents are also parents) Secondary entry points: • Community-based identification through CSOs and case management: identification of children who have not presented at a health facility, but are exhibiting signs and symptoms suggestive of HIV (poor weight gain, malnutrition, opportunistic infections, skin rashes, upper respiratory infections, chronic diarrhea, etc.)
Children & adolescents living with an HIV+ Adult	Primary entry points: • Adult care and treatment services, in order to conduct family tracing of index cases, generally prioritize high-volume sites and/or non-virally suppressed adults • Community-based support groups for HIV+ adults on treatment (e.g., mother-to-mother groups, PLHIV support groups)
Adolescent girls at risk in high burden areas	Primary entry points: • Girl roster • ANC and STI clinics • Protection services such as post-rape care and abuse case management, in collaboration with local government and CSOs
Children of key populations	Primary entry points: • Prevention and treatment programs designed to reach key populations
Children experiencing violence	Primary entry points: • Clinics providing post-abuse care • Social service providers for GBV/VAC case management • Community-based child protection committees/units • Home-based case management

• 2012 PEFPAR Guidance for Orphans and Vulnerable Children Programming; 3.2.1 Determining Program Beneficiaries, pages 20-21.

• OVC Technical Working Group (2017). Consensus Conference Technical Report on The Role of OVC Programs Supported By Pepfar In Extending Access To Hiv Testing Services: Rationale, General Considerations And Most Immediate Actions

• The Girl Roster Toolkit, Population Council; used within DREAMS programming: http://www.popcouncil.org/uploads/pdfs/Girl_Roster_flyer.POPCOUNCIL.2015.pdf.

2. ELIGIBILITY SCREENING AND ENROLLMENT

Criteria for screening and prioritizing children and caregivers for eligibility and enrollment in PEPFAR OVC programs should be HIV-sensitive, based on locally available and contextually appropriate data or information identifying which children are most vulnerable, objectively verifiable, and identified or agreed upon by key stakeholders (including, where possible, community members, program implementers, and government officials).

A standardized tool may be used to establish criteria, thresholds, or expectations for well-being and protection

(e.g., at least one meal a day, adherence to treatment among children living with HIV) and screen for and prioritize children and families who do not do not meet thresholds. These thresholds or criteria may also trigger emergency procedures intended to provide immediate response and enrollment in the OVC program (e.g., children living in abusive situations or suffering from life-threatening health conditions). Criteria for prioritizing OVC for enrollment may include indicators of extreme vulnerability, such as the presence of an HIV-infected individual in the household or experience of or exposure to violence. Criteria may also include a combination of indicators of high vulnerability, such as living in a child-headed household, living in a household where a child has gone an entire day and night without eating, or a household in which a school-age child is not enrolled in school. Additional criteria may include other indicators of vulnerability, such as the loss of one or both caregivers, chronic illness, or living in a household in which someone is chronically ill or in which there is poor nutritional status, irregular school attendance, poor psychosocial well-being, irregular access to safe water and shelter, or indicators of economic vulnerability. Screening for specific OVC subpopulations, such as adolescent girls, may include other criteria.

Screening and verification processes should be short, as objective as possible, and clearly understood by all actors engaged in the process. Processes will likely consist of a short series of "Yes" or "No" questions, some of which may be weighted more heavily than others. Some OVC programs send the results of screening processes to a central office or other decision-making body to prioritize cases for enrollment, in an effort to lend the process more accountability and objectivity.

Upon enrollment, the child and his or her caregiver are generally assigned a case worker (also referred to as a case manager). Case workers may be community volunteers or member of a community-based organization (CBO), non-governmental organization (NGO), or government body or professional social service workers. The case worker opens an individual case file for the child and caregivers (generally a family file; however, individual family members may have separate files within the family file). Files usually include a unique identifier, basic demographic information, the entry point from which the child and caregiver were referred, and the results of initial screening processes. If a child or caregiver received emergency assistance triggered by the initial screening, this assistance should be appropriately documented in the case file and case plan. Documentation should describe how the emergency was addressed (e.g., the date and type of service provided, and the location and contact information of the service provider) and the results or any additional actions to be taken. Case files may be paper-based, and stored in a secure file cabinet and/or electronically and password-protected to ensure confidentiality.

RESOURCE:

- Orphans and Other Vulnerable Children Household Vulnerability Prioritization Toolkit (Republic of Uganda Ministry of Gender, Labour and Social Development / MEASURE Evaluation)

3. ASSESSMENT

> → **Definition:** A process for identifying the specific needs and resources associated with children and their families.
>
> ✓ **Priority Actions:** Develop tools to guide assessment of priority needs of enrolled children and their households and the resources available to address these needs.

Comprehensive assessments are conducted for children and households that have been enrolled in the OVC program. They can explore issues related to socio-economic status, health, HIV status, nutrition, shelter, psychosocial well-being, education, and protection (including gender-based violence and domestic violence) that affect children and caregivers in the areas that an OVC program hopes to address (e.g., if an OVC program hopes to improve nutrition, an assessment should evaluate current nutritional status). It is important to assess individual children, as well as conditions affecting the family as a whole, and the ability of the family to care for children (e.g., household food security). Assessments should consist of discrete, measurable indicators (e.g., upper arm circumference), as well as collect qualitative information from a range of sources including individual interviews with children (where appropriate, and according to the age and evolving capacities of the child) and with their caregivers, interviews with extended family and friends, and interviews with health service providers, teachers of other education staff, and other service providers (e.g., police, court, other social service providers). Sources may also include reviews of medical records, education records, and police and court records, as well as observations during home visits.

Any assessment tool should be adapted carefully to the program and context in which it will be used. The dimensions of child well-being that are measured, the language used, etc., must reflect local cultural, geographic, and socio-economic conditions. It may be necessary to use a series of assessment tools, such as specialized tools for assessing economic vulnerability, health, nutrition, developmental delays, and child protection risks, in order to create a comprehensive picture of household strengths, assets, and available resources, as well as needs and vulnerabilities.

An assessment does not aim to assign specific vulnerability scores to cases. Rather, case workers use information collected in an assessment to inform the development of an individualized household case plan for children and their caregivers that is understood and "owned" by members of the household.

Due to the complex nature of the issues facing OVC and their caregivers, assessment is not a singular event within the case management process. Reassessment may occur as a result of changing circumstances within the household and at regular intervals as determined by the given program.

Please see the resources at the top of the following page.

RESOURCES:

- Vulnerability Assessment Methodologies: A Review of the Literature http://www.fhi360.org/sites/default/files/media/documents/Vulnerability%20Assessment%20Literature%20Review.pdf

- Measuring Mid-Upper Arm Circumference (MUAC) https://www.unicef.org/nutrition/training/3.1.3/4.html

- 4Children Namibia. "Matrix to Guide Risk Assessment" (adapted from Interagency Guidelines on Case Management and Child Protection, pp. 98-100) http://www.cpcnetwork.org/wp-content/uploads/2014/08/CM_guidelines_ENG_.pdf

- Washington Group on Disability Statistics/UNICEF. Module on Child Functioning and Disability https://www.cdc.gov/nchs/data/washington_group/meeting13/wg13_unicef_child_disability_background.pdf, or UNICEF/University of Wisconsin School of Medicine and Public Health. Monitoring Child Disability in Developing Countries: MICS3 Disability Module, p. 65 https://www.unicef.org/protection/Monitoring_Child_Disability_in_Developing_Countries.pdf

4. DEVELOPMENT OF AN INDIVIDUALIZED CHILD-CENTERED, FAMILY-FOCUSED CASE PLAN

→ **Definition:** A process for identify goals for a child and family and discrete actions to achieve goals.

✓ **Priority Actions:** Develop a written plan, including goals, actions, responsibilities for actions, a timeframe for carrying out actions and indicators for measuring completion of actions.

Within the context of PEPFAR OVC programs, a case plan tends to focus on an entire family (sometimes referred to as a household but recognized as including the primary caregiver(s) and all children); however, the family case plan can include individual subplans focusing on individual children and caregivers.

Case plans for a family and should include, at minimum:

- a clear description of the priority needs or problems that the case plan intends to address (e.g., poor adherence to HIV treatment, poor school attendance, inadequate nutrition, lack of regular income or savings, poor relationship between child and caregiver, caregiver

Depending on the goals of the OVC program, assessment reports may include the following information:

- **Date, location, and name of the case worker** conducting the assessment, and date and name of person with whom each assessment interview is conducted.

- **Biographical information** of each member of the household (name, age, sex, relationship to the child), orphan status, and marital status, if appropriate.

- **Economic status of the household,** including but not limited to employment status (position and location of employment), monthly or daily income, any assets (e.g., car, livestock, etc.), participation in any household economic strengthening activities, including social protection programs, and results of any economic vulnerability assessment.

- **Health:** vaccination status, chronic illness, access to and use of health care facilities, knowledge of basic health and hygiene, any significant disability of the child or caregiver, HIV status, and if positive, care and treatment regimen.

- **Nutrition:** number of meals per day, basic nutritional knowledge, safe and clean storage and preparation of food, access to healthy food (e.g., garden plot) and clean water.

- **Shelter:** description of the environment, does the caregiver own or rent the property, basic hygiene of the location, access to water and sanitation.

- **Psychosocial well-being:** any outward signs of or history of depression or mental illness, child/caregiver communication, attachment or bonding between child/caregivers and siblings. If HIV is in the household, important to discuss and document issues around disclosure, stigma, and discrimination faced by adults and/or children.

- **Education:** educational status of the caregivers, educational status of the child, overview of educational progress of child, review of any school reports or interviews with teachers.

- **Protection:** any outwardly noticeable signs of violence, abuse, exploitation, or neglect; overview of parenting practices, if child has birth certificate, concerns raised by caregiver or child about violence or abuse, stigma or discrimination of any kind within or outside of the household. Note that emergency SOPs should be adhered to if this issue is raised and response procedures are put into action.

In each of the domains, the case manager must aim to identify both the challenges or needs of the child and his/her household as well as the strengths and existing resources that can be built upon or leveraged as part of an ongoing case plan.

depression), as well as resources available to the child and family to assist in efforts to address needs or problems;

- an understood end goal or result of the case plan (i.e., a theory of change) that clearly outlines the goal and objectives that the child, caregiver(s), and case worker hope to achieve together (e.g., goal: self-sufficiency, improved ability to take care of children in the household, and to no longer require direct support from the OVC program; objectives: regular adherence to treatment, improved school attendance and performance, improved weight gain and health, increased savings/assets, improved communication between child and caregiver, reduction in depressive thoughts and attitudes);

- outcome indicators for determining when goals and objectives have been accomplished (regularly keeping treatment appointments for a period of at least six months, verified viral suppression, school absences of less than five days over a period of at least six month, passing scores on education exams and/or grade progression, improved MUAC scores, sufficient savings to pay school fees for an entire academic year, improved parent/child relationship verified by interviews with both parties, reduced depression according to a culturally appropriate, evidence-based depression scale);

- a series of actions to be completed to address needs, build on strengths and achieve the case plan goals and objectives (e.g., treatment referral and/or escorts, school fee voucher, nutrition counseling, cash transfers and/or enrollment in a village savings and loan association, enrollment in a parent-training and support group);

- the roles and responsibilities for all participants involved in implementing the case plan (e.g., case worker provides referral to treatment site and caregiver visits treatment site, case worker provides school voucher and caregiver enrolls children in school);

- a clear time frame for completing actions (e.g., within two weeks of receiving the treatment referral or school voucher);

- output indicators for determining when actions have been completed (e.g., treatment referral slip returned, child enrolled in school).

Note that actions may or may not include services. Some actions may simply be steps to be taken by the caregivers (e.g., provide space and time for child to study in order to improve school performance, engage child in an activity of his or her choosing at least once a week to improve child/caregiver relationship). It may be helpful to think about a case plan as a project that the household and case worker develop, implement, and monitor together. The case plan should include documentation of the child, caregiver, and case worker agreement with the plan, including agreement with any changes or additions to the plan, and evidence of

supplying the child and caregiver with appropriate and easily understood information and resources necessary to make informed decisions.

5. IMPLEMENTATION OF THE CASE PLAN

→ **Definition:** A process for completing case plan actions in an appropriate and timely manner.

✓ **Priority Actions:** Refer a child or caregiver to a specific service to assist in completing an action outlined in the case plan, provide a specific service directly, or support a child or caregiver to carry out an action on their own.

Actions may be completed by children and caregivers themselves, such as regularly attending school or taking medication without missing a dose. Actions may also be completed with assistance from the case worker and/or through receipt of specific services, such as parenting skills training, financial skills training, or enrollment in a saving group. Services may be provided by the case worker or the organization, or provided by another organization to which children and caregivers are referred by the case worker, such as statutory services provided by government bodies or HIV testing and health services provided by clinics. Programs do not typically have the resources or expertise to provide all services that a client might require. Making referrals to other organizations can ensure that clients receive high-quality services that are not available within the case worker's organization, but require additional coordination and follow-up to ensure that services are received, are of a high quality, and have the desired outcome. Managing referrals may also require an initial mapping of services available, the establishment of Memorandum of Understanding (MOU) agreeing to specific protocols for managing and tracking referrals and sharing client information, while at the same time maintaining confidentiality, the development of standardized tools and resources to facilitate referrals, and the identification of specific Referral Focal Points.

RESOURCES:

- 4Children. Referral Mechanisms within OVC Programming.

- 4Children. Referral Mechanisms case studies.

- MEASURE Evaluation (2013). Referral Systems Assessment and Monitoring Toolkit. https://www.measureevaluation.org/resources/publications/ms-13-60

- MEASURE Evaluation (2014). Strengthening the Monitoring and Evaluation of Referral Systems. https://www.measureevaluation.org/resources/publications/fs-14-117

- Institute of Development Studies (2012). Responding to the needs of vulnerable children in Eastern and Southern Africa; https://www.ids.ac.uk/files/dmfile/inf29.pdf

6. ONGOING MONITORING OF CASE PLAN IMPLEMENTATION

> → **Definition:** A process that involves meeting with the child, his or her caregiver, and other members of the household, service providers, or others who regularly interact with the child or caregiver to determine if and how the case plan is being implemented and to assess the likelihood that the goal and objectives will be achieved.
>
> ✓ **Priority Action:** Conduct regular home visits with the child and caregiver and other relevant stakeholders to note progress or challenges implementing the case plan, address urgent needs, and update the case plan as required.

The frequency of monitoring may vary, depending on the level of need and the interventions required. For example, children or caregivers in crisis may require more frequent, intensive, one-on-one support, while more stable or resilient children and caregivers can be supported to take more responsibility for their own well-being, and will require less frequent monitoring by case workers or monitoring can be achieved in group settings. In order to be counted as an "active beneficiary" under the OVC program, case workers must meet with a child and caregiver at least quarterly.

During monitoring visits to the child and caregiver's home, the case worker should identify any changes to the child or caregiver circumstances through interviews and observation, review the case plan to determine which actions have been completed and any challenges faced completing actions, raise any concerns or achievements noted by service providers or others who regularly interact with the child or caregivers, work with the child and caregiver to solve any problems or concerns preventing the achievement of the case plan goals and objectives, address any emergency concerns, make changes to the case plan as appropriate (e.g., adding additional actions, eliminating actions and/or changing actions to better address the child's and caregiver's current circumstances, and noting the child's and caregiver's approval of any changes), and document the visit through monitoring notes or a standard checklist.

For particularly complex cases, case managers may organize regular case conferences with service providers in order to share information and coordinate assistance. Case conferences explore multisector service options, and provide an opportunity to discuss the case and make recommendations and associated referrals for children and families. During case conferences, the case plan should be adjusted as necessary.

In addition to monitoring visits, more comprehensive reassessments should also be carried out on a regular basis, typically annually. A reassessment serves to identify any new or ongoing needs, priorities, and resources available to a child and/or caregiver. These reassessments may use the same assessment tools used by case workers during the

initial assessment, but should seek to build on initial findings. Direct comparison of results from assessments may not be possible because findings are often not objectively verifiable. However, regular reassessments should provide data that can be used to inform case plan indicators, give a sense of whether or not child well-being and protection has improved, and help determine the degree to which case plan goals and objectives will be realized and if the child and caregiver will achieve "graduation" within the project time frame.

Reassessments will also allow for a sense of the degree to which a case plan should be revised and how, e.g., if the case management goal and objectives are still appropriate or should be revised, if other concerns should be addressed or resources mobilized, if original concerns and strengths are no longer relevant, if additional or more appropriate actions need to be carried out by the same or different actors, and if indicators are appropriate or should be replaced. Again, any changes to the case plan must include documentation of child and caregiver approval.

7. CASE CLOSURE

> → **Definition:** A process involving the "closing" of case files within digital and/or physical file storage systems following the exiting of a child or household from the OVC program through case plan achievement, transfer, or the loss of a child or household to attrition.
>
> ✓ **Priority Action:** Document the process through which a child and caregiver exit the OVC program.

Most children and households exit OVC programming via three main pathways: case plan achievement, transfer, and attrition. Programs should have standard procedures for facilitating the exit of children and families via these pathways.

- **Case plan achievement**—Within the context of OVC programs, case plan achievement is broadly understood as the point at which all recommended interventions within a case plan have been completed, and the household has achieved both the goals and objectives of the OVC program, as well as their own goals within the parameters of the services provided under the given program. Case plan achievement has sometimes been referred to as "graduation," a term utilized within poverty reduction programs to reflect a state of improved economic stability. However, the term case plan achievement is used in the context of OVC programming to refer to the achievement of a range of objectives/goals, including but not limited to economic stability. Case plan achievement does not necessarily imply that households no longer require support, but rather that the OVC program and members of the household agree that caregivers in the household have demonstrated the ability to meet the needs of children in their care (e.g., regular attendance at school, adherence to HIV treatment, or positive parent-child relationships) to a reasonable degree, or children are able to meet their own needs, and the interventions offered by the OVC program are no longer

required. Steps associated with this pathway may include assessing readiness for case plan achievement, planning for case plan achievement with the child and/or household, continual monitoring for readiness, and conducting a final case review and case achievement ceremony for the child and/or household.

- **Transfer**—When it is not possible for a child or household to achieve their case plans and graduate from an OVC program or complete the recommended interventions outlined in their case plan, OVC programs should seek to transfer children and/or households to another source of support. "Transfer" within the context of OVC programs is understood as the shift of responsibility for case management and services to a child and/or household from one program to another program (e.g., another PEPFAR-supported program, a program supported by the national or local government, community-supported programs, or a program supported by another donor). Transfer occurs at the case level, and should not be confused with "transition," which is defined as the shift of responsibility for an overall OVC response within a community from donor support to local support and ownership. Transfer is appropriate when a child is on the verge of aging out of a program, or a household moves outside of the program catchment area before recommended interventions within a care plan have been completed and the child or household is ready to meet their own needs. Transfer is also appropriate when OVC programs are relocated to different geographic areas, closed, or their scope and funding are reduced before recommended interventions have been completed and households have achieved self-sufficiency. Steps associated with a transfer pathway may include identifying ongoing household needs and resources, identifying other support organizations or sources of support, developing agreements with service providers accepting transferred cases, providing assistance to improve the readiness of new service providers, pre-transfer planning with the child and/or household, facilitating introduction of clients to the new service provider and case managers, formal transfer of case files and other documentation to the new service provider, and follow-up.

- **Attrition**—In the context of OVC programs, attrition is the premature termination of support to a child and/or household due to circumstances beyond the control of the program. Attrition occurs as a result of the death of a child, a request by a child or his or her caregiver that services be discontinued, or the child and/or household's inability to abide by participation agreements. Attrition also occurs when efforts to locate the child and/or household fail, and the project is unable to provide services or case management. Cases of attrition should be confirmed and documented.

Once children and households have officially exited through any of these pathways and programs have terminated services, cases should be closed in digital and/or physical file storage systems. Programs are advised to store files for a period of time following case closure, keeping them accessible should future issues arise. The date on which files are closed, the case manager responsible for closing the file, and the resolution of the case (case plan achievement, transfer, attrition, or other) must be noted. Once the file is closed, the project ceases to provide active support or monitoring to the household, and ongoing projects are then able to enroll additional OVC households.

RESOURCE:

- [4Children (2017) Pathways for Exiting Programs for Children Orphaned or Made Vulnerable by HIV](#)

D. CASE FILES

Case files can be paper or electronic, but regardless should be easily accessible by the case manager. They should be stored in a safe and confidential manner (typically in a locked file cabinet and/or password-protected electronic file or encrypted mobile device). Files should include documentation completed prior to referral to the OVC program, completed screening or prioritization forms, enrollment forms with basic biodata information, a completed initial assessment and any reassessments and assessment reports, initial case plans and any updated case plans, case notes from monitoring visits, documentation associated with referrals or documentation of completed actions (e.g., referral return slips, school progress reports), and documentation of the circumstances of case closure.

E. CASE WORKERS

> → **Definition:** A **case worker** (also referred to as a **case manager**) may be a volunteer or a professional. He or she may be a member of a community-based organization (CBO), non-governmental organization (NGO), or government body. The case worker is responsible for developing and monitoring plans for improving the well-being of a child, coordinating actors and actions involved in achieving the objectives of the case plans, making or facilitating referrals to appropriate services, and ensuring that decisions related to the case plans are in the best interests of the child.

Case management is typically the responsibility of a case worker.

1. *Training and supervision*

Case workers should be adequately and regularly trained and supervised. Training should ideally be provided through a recognized training program or institution, and result in a case management qualification or higher. Qualifications should be supplemented by relevant and ongoing continuing education. Supervision should be provided regularly in an individual and/or group setting by a qualified and experienced supervisor. Supervision meetings should review case files for completion and accuracy, collect data for OVC program monitoring, encourage case workers to give verbal reports on cases—including successes and challenges associated with

cases—promote opportunities to problem solve and identify ways to better enable children and caregivers to achieve case management goals and objectives, provide emotional support to case workers experiencing stress as a result of case management responsibilities or other life concerns, and educate case workers on new procedures, best practices, and resources.

2. *Caseloads*

Caseloads should be reasonable and reflect the complexity of the cases. Generally, more complicated cases (such as those that involve child abuse) should be managed by case workers with higher qualifications and/or experience. In addition, caseloads that include more complicated cases or cases that require more intense monitoring should generally be smaller. Cases that require less intense monitoring may be managed by less qualified, less experienced case workers under close supervision.

3. *Confidentiality and client consent*

The case manager should adhere to applicable local, state, and federal laws, as well as employer policies governing the client, client privacy, and confidentiality rights, and act in a manner consistent with the client's best interests. Case workers should sign confidentiality agreements that detail these policies. At a minimum, policies should outline how case workers should instruct case workers to keep case files and any documents identifying clients in a safe space and not discuss the details of a case with anyone not directly involved in the case or who hasn't signed a confidentiality agreement. Case workers should seek to obtain the child's and caregiver's written acknowledgement that he or she has received notice of privacy rights and practices, and consents to services. Case workers should also ensure that the child and caregiver are aware of the costs and benefits of participation in the OVC program, including potential risks to participation or alternatives to participation in the OVC program, and that they have the right to refuse or terminate services at any point, as well as the potential risks and consequences related to such a refusal.

4. *Ethics and child safeguarding*

Case workers should behave and practice ethically, and adhere to their organization's child safeguarding policy. They should sign their organization's child safeguarding code of conduct, and consider themselves mandated to report suspicions of abuse through appropriate channels.

5. *Advocacy*

Case workers should advocate for their clients at all levels, including service-delivery, organizational, community, and government/policy levels. They should educate service providers to recognize and respect the needs, strengths, and goals of their client, as well as recognize, prevent, and eliminate disparities in accessing high-quality services due to stigma and discrimination. Case workers should also advocate for expansion or establishment of services not currently available.

6. *Cultural Competency*

Case workers should be aware of, and responsive to, the cultural and demographic diversity of the population and their clients. They should understand relevant cultural information and communicate effectively, respectfully, and sensitively within the client's cultural context and language.

Annex 1: PEPFAR Sims Community Tool—Set 3: Orphans And Vulnerable Children (OVC)

CASE MANAGEMENT SERVICES

> **SIMS STANDARD**
> The organization assessment point has standard procedures for identifying, assessing, enrolling, and monitoring children and families affected by and vulnerable to HIV in an OVC program.
>
> **APPLICATION**
> The Case Management CEE is *required to be assessed for all implementing partners providing OVC services*, including facility-based partners.

Assessment Items

The PEPFAR SIMS Community Master Tool (Version 2.0, December 18, 2015) includes the following questions related to Case Management Systems.

	QUESTION	RESPONSE	SCORING
Q1	Does this assessment point have a standard process for identifying, assessing, and enrolling the most vulnerable children in a community?	Y N	If N=Red
	If Y, then Q2		
Q2	Does this assessment point maintain confidential case files (can be observed by the following examples: file storage practices, accessibility to the files) with care plans for children and their families identified as vulnerable?	Y N	If N=Red
	If Y, then Q3		
Q3	*Review 10 beneficiary/client records (individual or logbook) from within the last three months.* Do 100% of the case files show that the assessment point monitors case/care plans for children and their families identified as vulnerable in at least three of the last four quarters (i.e., care plan has been updated every three months)?	Y N	If N=Yellow
	If Y, then Q4		
Q4	Does this assessment point have a process for closing files and transitioning children and their families from program support?	Y N	If N=Light Green If Y=Dark Green
	SCORE		