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SUMMARY OF KEY FINDINGS FROM THE 4CHILDREN CASE MANAGEMENT CASE STUDIES

SCORE Project in Uganda

Yekokeb Berhan Project in Ethiopia

The Zimbabwe National Case Management System

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome	IP	Implementing Partner
ART	Antiretroviral Therapy	KII	Key informant interview
CBO	Community-based Organization	LCCW	Lead Community Childcare Worker
CC	Community Committee	MIS	Management Information System
CCC	Community Care Coalition	MGLSD	Ministry of Gender, Labour and Social Development
CCW	Community Childcare Worker	MoH	Ministry of Health
CDO	Community Development Officer	MOLSA	Ministry of Labour and Social Affairs
CHW	Community Health Worker	MOWCYA	Ministry of Women, Children and Youth Affairs
CLV	Community Legal Volunteers	MPSLSW	Ministry of Public Service, Labour and Social Welfare
CMO	Case Management Officer	NAT	Needs Assessment Tool
CP	Child Protection	NAP	National Action Plan for Orphans and Vulnerable Children
CPC	Child Protection Committee	NCMS	National Case Management System
CSI	Child Support Index	NGO	Non-Governmental Organization
CSO	Civil Society Organization	OVC	Orphans and Vulnerable Children
CWO	Child Welfare Officer	PEPFAR	U.S. President's Emergency Plan for AIDS Relief
DCWO	District Child Welfare Officer	PSW	Para-social Worker
DCWPS	Department of Child Welfare and Probation Services	UNICEF	United Nations Children's Fund
DSS	Department of Social Services	USAID	United States Agency for International Development
FGD	Focus Group Discussion	WEI/B	World Education Inc. / Bantwana
HES	Household Economic Strengthening		
HIV	Human Immunodeficiency Virus		

Glossary of Terms

Child Protection Committees are multi-sectoral and multi-stakeholder structures put in place at national and sub-national levels to coordinate implementation of child protection interventions at each level. They provide technical advice, mobilize political commitment and advocacy, mobilize resources and create synergies with other related programs, and advocate with local authorities, government institutions, private sector, and donors to prioritize commitment of resources and ensure collaboration among stakeholders. They also report yearly progress for children, meet to discuss priorities, oversee grants, and ensure child participation.¹ (Zimbabwe)

Case Management Officers are non-statutory, registered social workers seconded at the District Departments of Child Welfare and Probation Services holding the same responsibilities as the child welfare officers, except that they cannot make child removal decisions or appear on behalf of children in court.² (Zimbabwe)

Community Childcare Workers are a cadre of workers recruited at the community level from village Child Protection Committees (child protection structures) to identify vulnerable children in their communities.³ (Zimbabwe)

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. The CDO is responsible for sensitizing the community on legislation on gender and child rights. (Uganda)

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. (Uganda/SCORE)

Community Committee: A community committee is a coalition that is comprised of interested and voluntary individuals, groups, and associations that represent different sectors of the local population, government, and other organizations. The community committee is present at kebele and sometimes at woreda level. Within the Yekokeb Berhan program, the main purpose of the community committee is the prevention of social problems and the amelioration of adverse conditions that affect people (especially children) in difficult circumstances. The intent is for this to be done in a systematic, sustainable manner that can have long-lasting impact on the affected child or family, and can extend – as a system – beyond the life of the program.⁴ (Ethiopia)

Community Care Coalition: A community care coalition (CCC) is a community-based structure, recognized within the National Social Protection Policy. The National Social Protection Policy describes a CCC as a coalition of community services representing different parts of the society and involving volunteers who are working to solve and alleviate social and economic problems in their areas.⁵ Its primary function is to act as a hub for community leaders to identify, refer, and monitor support to vulnerable populations. This can include but is not limited to the provision of cash grants, enrollment in social service programs, and home visitations by community-based volunteers or para-social workers. CCCs are established by the government and supported with regulations issued by the Regional Government Council. CCCs are present at kebele and woreda levels. They are designed to address vulnerability of all populations, including children, but also the extremely poor, disabled, and the labor-constrained. (Ethiopia)

District Child Welfare Officers are social workers employed in a district under the Department of Child Welfare and Protection Services. They have statutory authority for case management in child abuse and neglect cases, removing children from homes, deciding alternative placements, and appearing in court for all child-related matters. Cases of abuse and neglect are reported by community childcare workers (CCWs) to the child welfare officers who manage cases and/or refer to specialized services.⁶ (Zimbabwe)

Para-social Worker: Over the past several years, the Government of Ethiopia through the Ministry of Labour and Social Affairs has utilized USAID funding to roll out the training of para-social workers (PSWs) using a government-endorsed curriculum based on approved occupational standards.⁷ The PSWs are recognized positions within the kebele- or woreda-level government structure. They are primarily responsible for working closely with the CCC/kebele to identify, assess, refer, and provide follow up to vulnerable members of the community (more than just children). PSWs are also being supported and institutionalized within the Government of Uganda Social Welfare System, overseen by the Ministry of Gender, Labour and Social Development. (Ethiopia, Uganda)

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. (Uganda)

1 Ministry of Labour and Social Services (2011). National Action Plan for Orphans and Vulnerable Children Phase II, 2011-2015

2 Ibid.

3 Ministry of Public Service, Labour and Social Welfare (2015). National Case Management System for the Welfare and Protection of Children in Zimbabwe

4 Yekokeb Berhan (2014). Yekokeb Berhan Program Standard Operational Guidelines for Implementing Partners

5 Federal Democratic Republic of Ethiopia, Ministry of Labour and Social Affairs (2013). Social Protection Policy.

6 Ibid.

7 Federal Democratic Republic of Ethiopia (2013). Occupational Standard Community Service Works NTQF, Level I, II, III, IV and V.

Objectives of the Case Management Case Studies

PEPFAR's OVC programming delivers child-focused, family-centered interventions that seek to improve well-being and prevent 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. 4Children has prepared a series of case studies documenting the core components of the case management process within orphans and vulnerable children (OVC) programming and national child protection systems, in three different countries: The Yekokeb Berhan Project in Ethiopia, the Sustainable Comprehensive Responses for Children and their Families (SCORE) Project in Uganda, and the National Case Management System (NCMS) in Zimbabwe, developed with support of the Vana Bantwana Initiative.

These case studies, developed through an extensive process of consultation with USAID and implementing partners, review of programming reports, country-specific documentation and other literature, and in-depth field work, aim to provide examples of how case management can be used to support work with vulnerable children and families affected by or living with HIV. The experiences, approaches, and tools used by the three different programs share some commonalities as well as challenges and lessons learned. However, they also provide unique examples of how to build on or integrate case management into existing systems and structures at local and national levels, and how to integrate a case plan achievement approach into OVC programming. As the sector begins to embrace the role that a case management process has within OVC programming, these case studies provide concrete examples of how to design and implement case management, including recognition of the challenges that accompany this process.

SELECTION OF THE CASE STUDIES

The case management systems documented in the three case studies were selected to illustrate the core components of specific case management systems, the positive results of each case management system, and some of the challenges in designing, implementing, and solidifying a case management system within an OVC program. The three case studies were suggested because there were certain design elements, approaches, and/or tools that were recognized as being particularly interesting, innovative, or useful to consider. Each of these systems were deemed highly effective, but not perfect, by program staff and beneficiaries alike. The information presented should be understood as examples of case management systems in practice. Any case management system should be adapted to best reflect the context in which it is utilized, the target population it serves, and the programmatic needs of the implementer.

METHODOLOGY

The information used to inform all three case studies was collected through a combination of a desk review of project documents and visits to Uganda, Ethiopia, and Zimbabwe to conduct key informant interviews (KII) and focus group

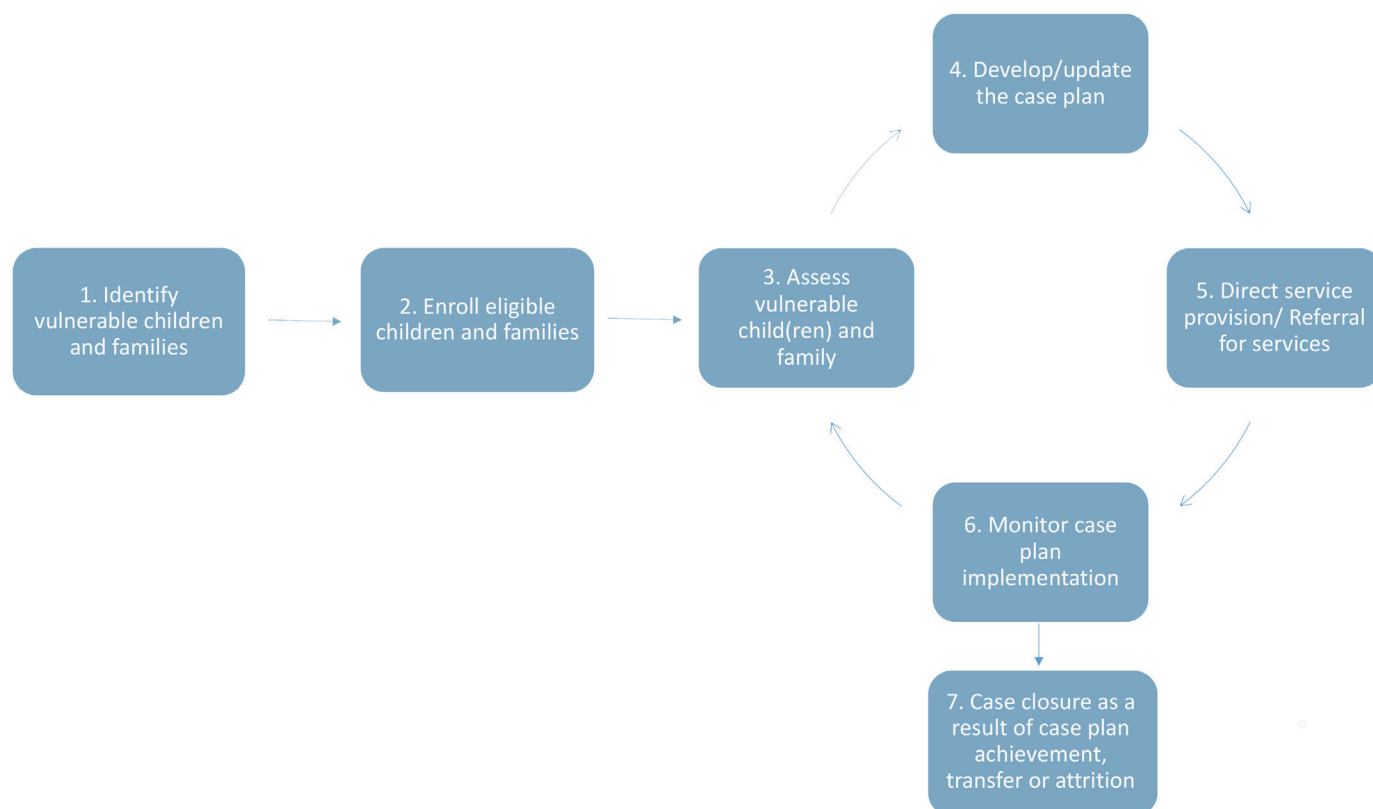
discussions (FGD). Each field visit included both urban and rural site visits and discussions with stakeholders and beneficiaries from village to national levels, including interviews with local and national government officials and project leadership. All attempts were made to have equitable gender representation in the KIIs and FGDs. The documentation process was not conducted as an assessment, but with a focus on documenting how each case management process and the relevant tools and approaches to support the process worked in practice from the perspective of those responsible for specific components of the case management system and those whom the system is intended to serve. This summary is intended to provide an overview of each of the three systems, their respective strengths and weaknesses, and how they fit into the evolving landscape of OVC programming and the changing standards around case management, including key components such as case plan achievement (formerly referred to as graduation), systems strengthening, and referral mechanisms.

Case Management within OVC Programming

In the context of OVC programs, case management can be understood as the process of identifying, assessing, planning, referring and tracking referrals, and monitoring the delivery of services in a timely, context-sensitive, individualized, and family-centered manner to achieve a specific goal (e.g., child protection and well-being). Case management involves significant collaboration with the client unit—in this case the child and his or her caregiver (i.e., the family)—and utilizes problem-solving and empowering approaches aimed at increasing resiliency. Case management should build on the existing resources and strengths of the client to help inform decisions about which interventions or services clients require, who can provide them, at what intensity, and for how long. It improves coordination and integration between and among different sectors, facilitating the delivery of multiple services, and reducing gaps in services in order to increase clients' access to and uptake of services that meet their unique and priority needs and achieve their case plans.

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 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 the family has demonstrated the ability to meet the needs of children in their care to a reasonable degree, and the interventions offered by the OVC program are no longer required.

Figure 1: Case Management Process



There are seven critical steps in the case management process as shown in Figure 1.⁸ These steps include: 1) identifying vulnerable children and families, 2) enrolling eligible children and families, 3) assessing children and families for programs (reassessment may occur as a result of changing circumstances within the household and at regular intervals as determined by the given program), 4) developing a household case plan, 5) implementing the case plan, which includes direct service provision and/or referrals for services, 6) monitoring progress made toward case plan and program goals through on-going assessment, and 7) closing cases following the exit of clients due to achievement of their case plan goals and objectives, transferring to another source of support, or attrition.

SHIFTING EXPECTATIONS FOR OVC PROGRAMS

An overall aim of PEPFAR's OVC programming is the delivery of child-focused, family-centered interventions that seek to prevent the abuse, neglect, exploitation, and separation of children and to promote healthy and safe family-based environments for children affected by HIV and other adversities.⁹

Over the past few years, OVC programming has increased efforts to build the resilience of households (caregivers and children) to address challenges and to provide a safe and healthy environment that fulfills a child's basic needs without direct program support. This approach takes concentrated planning and monitoring of the case plan as well as strategic linkages with other service providers and support offered within a given community. A case management approach plays a critical

role in supporting this shift to longer term, sustainable, and resilience-focused programming. Protocols related to reaching identified goals are included in each of the three case management case studies. However, it is important to note that the concept of case plan achievement (formerly "graduation") within OVC programs was a relatively new concept at the time these projects were designed, and thinking around good practice has evolved, including the use of agreed-upon and standardized definitions.

Approaches to systems strengthening have also had a significant impact on the OVC field in the last decade. Taking a systems approach is essential and supports important opportunities to link with government and other service providers in a systematic and institutionally sound manner. In many cases systems strengthening efforts are prioritized to support and prepare for the pivot as projects, communities, CSOs, and governments prepare to work toward independence from externally funded services and interventions.

This report summarizes the strengths, challenges, lessons learned, and remaining issues or gaps in the SCORE Project in Uganda, the Yekokeb Berhan Project in Ethiopia, and the Zimbabwe National Case Management Systems (NCMS) in designing case management systems that are influenced by and responsive to the changing OVC programming landscape explained above. It is intended for program designers, managers, and practitioners, and is intended to help them better understand how a functional case management system can be designed, embedded, and used as a guiding framework

⁸ Graphic informed by Center for International Social Work at Rutgers University's School of Social Work and International Social Service-USA for USAID (2014). [Case Management Toolkit: A User's Guide for Strengthening Case Management Services in Child Welfare.](#)

⁹ President's Emergency Plan for AIDS Relief (PEPFAR) (2012). [Guidance for Orphans and Vulnerable Children Programming.](#)

for existing or new OVC programs. It also highlights the remaining challenges and the work that needs to be done to meet new OVC standards and best practices to more effectively serve vulnerable children and families affected by or living with HIV.

Strengths and successes

CASE MANAGEMENT SYSTEMS ARE DESIGNED FOR AND ADAPTED TO THE LOCAL CONTEXT, INSTITUTIONS, AND POLICY FRAMEWORKS.

Across the three case studies, the concept of case management is used to describe a coordinated response to children and families, following the seven steps of the case management process outlined above. Each system is purposefully adapted to the local context, the project needs, and where possible, integrated into or linked with statutory systems to prevent and respond to violence against children.

Integrated into broader social welfare systems strengthening efforts, the **Zimbabwe NCMS** defines case management as *a way of organizing and carrying out (the) work (of the Zimbabwe Department of Child Welfare and Protection Services) so that children's cases are handled in an appropriate, systematic, and timely manner. It aims to ensure that through coordinated, collaborative care, children can receive the services they need.*¹⁰ The Zimbabwe NCMS provides standard national guidance to link community volunteers to statutory social welfare systems, with clear guidance on their respective roles within the case management process.

Yekokeb Berhan defines case management as *coordinated care*, a concept which describes the process of identification, assessment, referral, and follow-up to link children and their families with necessary and locally supported services. In Yekokeb Berhan's definition and conceptualization, case management is focused as much on systems and community-level actions as on the individual child or family. The integration of the case management approach within government structures and processes helps to ensure the long-term sustainability and institutionalization of case management within the social welfare system.

The SCORE case management and graduation model combines concepts from social work, household economic strengthening, and robust monitoring and evaluation standards, and is designed to monitor progress and to support enrolled household/clients to "graduate" from direct project support once they achieve self-sufficiency. In addition to the project case management and graduation model, SCORE provides specific case management guidelines and tools to respond to child protection violations with linkages to sub-county and district statutory systems, and to respond to acute malnutrition with linkages to clinics and supplementary feeding programs. The SCORE case management and graduation model is otherwise designed to function independently within the project structure.

Case management systems build on, leverage, and clarify linkages between community volunteers, statutory social workers, and project staff.

Both the **Yekokeb Berhan and Zimbabwe NCMS case management models** involve government institutions and processes at all levels from the most local levels to the national level. In Yekokeb Berhan, case management is conducted by community volunteers supported by implementing partners (IPs), as well as community care coalitions (CCCs) or community committees (CCs), which provide institutional support and act as a central hub for the case management process. Each is housed in an office and is comprised of 10 to 23 community members (typically recognized leaders and representatives of different community bodies) who come together regularly to coordinate care. While not yet established across all of Ethiopia, the CCCs are institutionalized under the National Social Protection Policy.

The NCMS model also involves community volunteers, titled Community Childcare Workers (CCW). CCWs are part of the para-social welfare system, and there are now 9,500 CCWs across all 65 districts in Zimbabwe. CCWs do not receive a regular stipend, but do receive bicycles, logo uniforms and t-shirts, cellular phones and air time, consumable office materials, solar lanterns, and solar power stations, i.e., tools of the trade. CCWs manage an average caseload of five to seven open family cases at a given time, and are overseen by a Lead Community Childcare Worker (LCCW), tasked with linking them to district-level statutory child protection services. The LCCW also carries up to seven open family cases, and meets with peers every month on average to review cases, share ideas and strategies, and solve problems.

In **Zimbabwe**, statutory child protection positions at the district, provincial, or national levels include the Child Welfare Officer (CWO) and Case Management Officer (CMO). These positions are held by professional (university-trained) social workers. CWOs are the first-line statutory workers, with responsibility for receiving referrals of abused, neglected, or separated children, managing these cases, and coordinating services at the community level. CMOs share these responsibilities, but do not have the statutory authority to remove children from home or to represent a child's interest in court. There are now fewer than 900 professional social workers registered in Zimbabwe, reflecting a serious shortage of trained social workers. According to government stakeholders, the NCMS system and national guidance have simplified the work of the social service workforce at both the local and district levels, improving coordination and communication.

Both the **Yekokeb Berhan and Zimbabwe NCMS** also organize regular *case conferences*, bringing together CCC members, community childcare volunteers, project staff, and statutory social workers to review cases, problem solve, and identify priority actions. Case conferencing is recognized as a helpful way to foster collaboration between different actors representing a wide range of organizations, structures, and sectors, and promotes sharing of information and recommendations to inform a holistic response to the varying needs of vulnerable children and families. Furthermore, case conferencing acts as an important supervisory and learning process for the volunteers and others involved in the case management process.

10 Ministry of Public Service, Labour and Social Welfare (2015) National Case Management System for the Welfare and Protection of Children in Zimbabwe, p. 21

Case management within the SCORE project, by contrast, is primarily managed by project staff, with linkages to community volunteers working on other technical interventions within the project. Although staff titles vary by implementing partner (IP), most are social service workers with varying qualifications and technical expertise. All project officers, irrespective of the sector, are responsible for family case management and support or directly manage all steps within the case management process. Their caseload is far less standardized than in the Yekokeb Berhan or NCMS system, and each officer is a case manager for between 8 and 100 households.¹¹

CASE MANAGEMENT SYSTEMS ARE LINKED TO AND PROMOTE STRONG REFERRAL MECHANISMS.

All three case management systems are viewed by stakeholders as highly effective at ensuring children and households receive the services they require. Both **SCORE and Yekokeb Berhan** provide relatively comprehensive services directly through the project, while the Zimbabwe NCMS provides outreach to caregivers and children through Family Clubs. All projects have a robust referral mechanism in place, but still face challenges ensuring regular access to non-project services, especially in remote areas with a limited number of service providers. Within the SCORE project, there is sometimes a gap between the household development plan and activities, but project staff explained this is due to shifting household priorities rather than a lack of access to services.

Each of the three projects and case management systems follow a similar process to establish and maintain referral mechanisms and coordination of services with other service providers. This starts with a community service mapping and routine updating of the service provider map/directory. Strong networks, regular meetings, and ongoing coordination are highlighted as key to the referral mechanisms' success.

SCORE, Yekokeb Berhan, and NCMS also use official referral forms to manage referrals. SCORE offices use a referral log to monitor and follow up on any outstanding referrals, and provide triplicate copies of referral forms: one for the project, one for the client, and one for the secondary service provider. Where a specific service was needed by many community members simultaneously, such as HIV testing or legal counseling, the project organized community clinics or aggregated referrals to bring an outside service to a large number of beneficiaries at the same time.

Gaps and challenges

CASE MANAGEMENT SYSTEMS CAN BE STRENGTHENED TO BETTER TARGET AND REACH HIV-AFFECTED CHILDREN AND FAMILIES, ESPECIALLY CHILDREN LIVING WITH HIV, TO SUPPORT THE 90-90-90 EFFORT.

For PEPFAR purposes, in all epidemics, children should be identified through: 1) HIV-specific services; 2) social services; 3) key and priority populations initiatives. While both the **Yekokeb Berhan and SCORE** systems included HIV in their identification protocol, HIV status was included alongside

other more generalized vulnerability indicators. These and similar protocols relied on clinics to proactively identify and refer children to OVC community partners, which rarely happened systematically. Additionally, OVC projects quickly met enrollment quotas through community identification without having to directly rely on clinic referrals.

The balance between community and clinic identification and cross-referral is hard to achieve, but essential to ensuring that programs reach children who are infected (clinic), affected (orphaned), and at risk of HIV.

PEPFAR programs are under increasing demand to improve HIV-sensitive targeting through proactive identification, assessment, and enrollment, especially for HIV-affected children (children with HIV-positive family members) and children living with HIV found through clinics. In numerous countries, this has involved placing OVC case managers or other OVC frontline workers at clinics at regular intervals to facilitate cross-referrals—the **WEI and Yekokeb Berrhan** projects have begun to pilot this model. The **SCORE project** has also begun identifying HIV-affected and HIV-infected children and families through health facilities and clinics, as well as continuing to identify vulnerable children, particularly vulnerable adolescent girls, through community mechanisms.

While referral mechanisms were generally deemed successful across the three projects, challenges were also identified. Because the **Zimbabwe NCMS** is limited in the direct service provision it is designed to provide, it relies heavily on other stakeholders. In some locations, the dearth of available services presented a challenge. Conversely, for **SCORE and Yekokeb Berhan**, bi-directional referrals remain a challenge, and both projects often operate near capacity and may be unable to provide services to significant numbers of vulnerable children and families referred to them by other service providers. OVC programs (including SCORE and Yekokeb Berhan) are increasingly encouraged to focus on improved targeting and identification protocols, as well as strong graduation protocols to make sure there is space in the program for HIV-affected children and families. Thus, it is increasingly important that systems are put in place to encourage and facilitate bi-directional referrals, including coordinated case management processes.

The **Yekokeb Berhan project** has also increased focus on HIV during implementation, developing supplemental guidance on *How to Better Serve HIV-affected Children and Families*, recommending renewed focus on health and HIV testing and treatment referrals, prioritization of known HIV-affected or HIV-positive children and families, additional support to HIV-positive caregivers, and additional training on HIV prevention and counseling skills related to disclosure and confidentiality. While a more generalized approach to identification is appropriate for a national social welfare system, such as the Zimbabwe NCMS, violence against children is recognized as also being a key risk factor for HIV. Therefore, facilitating linkages to counseling and testing within the statutory child protection system may also be appropriate.¹²

¹¹ KII Rita Larok, email: 6/28/16.

¹² Long, S., and Bunkers, K., (2013) on behalf of IATT, UNICEF and World Vision. Building Protection and Resilience: Synergies for Child Protection Systems and Children Affected by HIV and AIDS.

VULNERABILITY ASSESSMENTS ARE TOO SUBJECTIVE IN SOME CASES, AND TEND TO FOCUS ON PROBLEMS RATHER THAN STRENGTHS AND RESOURCES.

The assessment and care planning processes functioned well within the case management systems featured in the case studies. In all three examples, following a systematic assessment and care-planning process assisted the community volunteers, project staff, and representatives from the social service workforce to provide tailored services to children and families. However, the assessments within all three projects did not include sufficient questions focused on identifying strengths and resources of the household. The focus on vulnerability rather than resilience places the emphasis on the intervention and what the project can provide, without directly encouraging the household to realize their own strengths, resources, and capacities. Although the **SCORE** Needs Assessment Tool (NAT) applied after the Vulnerability Assessment Tool (VAT) does include sections for strengths and household contributions, it is less systematic than the vulnerability assessment, and in practice, is often given less attention by the project officers completing the forms.

In addition, the **Yekokeb Berhan** Child Support Index (and the original Child Status Index) are overly subjective. The Child Support Index is a comprehensive assessment of the economic security, health, nutrition, safety, psychosocial, and education needs and vulnerabilities of the child and household, as well as HIV and disability status. Each of the 20 areas of assessment are assigned a score from 1–4 (1 is worst/lowest and 4 is the best/highest), depending, in part, on the judgment of the assessor and family, and does not rely on objectively verifiable determinants of vulnerability.

The original CSI and other scored assessment tools have recently come under criticism for over-simplifying vulnerability. Because vulnerability is not fixed, a child or household's degree of vulnerability can change very quickly. Furthermore, quantifying vulnerability is a complicated, and as noted, often subjective, process. It implies a level of objectivity that may not be possible. Reducing a description of vulnerability to a number score may mask serious vulnerabilities, and using that score to compare children and rank vulnerability may exclude children who are suffering extreme abuse or facing other significant risks, but who are otherwise stable from receiving much needed services (e.g., children living in abusive households, but attending school, or children living with HIV who are not adhering to treatment, but eat three meals a day). This is particularly true within ranking systems that do not weight scores (e.g., systems that do not give a higher weight to abuse or a positive HIV status).

The NCMS assessment is appropriate for its intended purpose: to evaluate a child who is a victim of a children's rights violation. The Zimbabwe NCMS assessment includes questions on the child's physical status, psychological status, social functioning, cognitive/educational needs, losses or previous trauma, and other problems that need to be addressed by the social welfare system. It does not include objective measures

of vulnerability or enrollment criteria, as it is designed to inform the response to child protection violations, rather than to determine whether the child requires support.

CASE PLANNING DOES NOT SYSTEMATICALLY FACILITATE HOUSEHOLD PARTICIPATION, COMMITMENTS, OR GOAL SETTING.

As case management processes evolve within the OVC sector, learning from the field of social work, proactive engagement of and ownership of the process, including the identification of strengths and goals of the child and household, is critical. While recognizing that children targeted by OVC programs are some of the most highly vulnerable and marginalized, it is also critical, as service providers responsible for assessing these families and developing case plans, to recognize that all families have existing strengths and resources. They might need to be reminded of these, but it is the role of the OVC program, and especially the person doing the assessment, to help the household identify these and build on them.

The Yekokeb Berhan Child Support Index tool does not solicit household contributions or goals. In addition, it limits the household case plan to a service delivery code included under each assessment category of the CSI. This saves time, but does not facilitate strengths-based planning, and frequently reduces the services included in the case plan to the select service delivery codes memorized by the community care worker.

The SCORE Household Development Plan includes a brief assessment of access to services and two sets of columns to record project-supported services and household contributions. It does not include a section to develop or record household goals, but it does encourage project staff to engage caregivers and the household head in committing to their roles within the project.

While the Zimbabwe NCMS assessment and care-planning tools are designed for child protection purposes, they also lack clear protocols to involve children and families in both the assessment and care planning process. This is identified as an area for further improvement to ensure the NCMS is designed to address the self-defined priority needs of children and families.

THE CONCEPT OF CASE PLAN ACHIEVEMENT IS NOT READILY UNDERSTOOD OR APPLIED IN A CONSISTENT MANNER.

While all three case management systems included some type of graduation protocol,¹³ there were differences in how the three programs defined and integrated this type of approach into the case management process. Similarly, there were different criteria used to assess whether or not a client was ready to exit the program (i.e., has reached case plan achievement and no longer requires direct program support). It is important to remember that this concept is relatively new to OVC programming, and has been steadily evolving since the time that the three OVC projects were designed. The change in terminology from graduation to "case plan achievement" is reflective of the increasingly critical roles of case management and care-planning processes in OVC projects, helping caregivers and case workers to partner to "establish specific, realistic goals and plan actions to achieve goals, to implement plans,

13 The terms "graduation" or "case closure" were used by the three OVC programs at the time the field visits were conducted. However, the definition, measurement to determine readiness, and processes involved were different across all three programs. Currently, the term case plan achievement is being promoted to capture the state of meeting the goals outlined in the case file, as well as the goals of the OVC program.

and monitor the completion of actions and progress toward achieving goals.” The term case plan achievement endeavors to capture a more individualized and holistic approach to promote health, education, economic stability, protection, referrals/access to other services, and psychosocial well-being. As a result, there are differences in understanding of the case plan achievement concept, and varying terms and approaches used by the three different programs in each of the individual case studies.

Both **SCORE** and **Yekokeb Berhan** use one single vulnerability assessment tool for enrollment, monitoring, and to assess graduation readiness (the VAT and CSI, respectively). In the **SCORE** project, a household is considered eligible for graduation when the household scores below 40 on two consecutive assessments over a 24-month period. Once this occurs, the project officer working with the household organizes a graduation ceremony and closes the case file, moving it to a different storage location within the office, and opening a space to enroll new households.¹⁴

Likewise, the Yekokeb Berhan case care worker uses scores on the CSI to determine eligibility for graduation and graduate households once scores have improved from 1s and 2s to 3s and 4s, reflecting improved well-being and stability. Unlike **SCORE**, the Yekokeb Berhan project uses the term graduation to describe all cases of case closure, including the child transitioning to another program, opting out of the project, or reaching the age of 18 and aging out of the program. Neither the **SCORE** nor the Yekokeb Berhan program systematically assesses the completion of the case plan or achievement of case plan goals when determining graduation readiness. Furthermore, there has been very limited collection of data on child well-being after the child and household exit the program. The lack of such “tracer” studies is a recognized limitation in terms of better understanding if the criteria used to determine when a household is able to leave the OVC project is appropriate in terms of its assessment criteria.

The **Zimbabwe NCMS** case closure protocol is more focused on the individual case plan rather than objective measures. According to the NCMS protocol, “the goal of case management is to meet the needs of a child to the degree where there is no longer a need for case management services.”¹⁵ However, NCMS stakeholders commented that in practice, it is challenging to determine when children or families are ready to move beyond support from the program and to determine readiness without clear criteria. This challenge is compounded in a resource poor context, where there are few accessible services to continuously support children.

Considerations for case management in OVC programming

CONTINUED FOCUS ON HUMAN RESOURCES AND THE SOCIAL SERVICE WORKFORCE

Case management, by design, is time intensive and demands appropriate training, skills, sensitivity, and commitment by the case workers responsible for coordinating services for vulner-

able children and families. While not all vulnerable children are in need of case management, pervasive violence against children and the widespread impact of HIV and other adversities on children and families have overwhelmed statutory child protection systems in most countries, particularly in the contexts where PEPFAR-funded programming is implemented. This has led to an increasing reliance on volunteers and the para-social workforce, established cohorts of representatives at the community level with a mandate to act as first responders to child protection violations in their communities, and case workers for children and families, ideally with strong linkages to statutory systems and service providers in their communities or districts.

Establishing, formalizing, training, and supporting this workforce are not without costs, and those looking to establish new systems should carefully consider the time required for each step, the capacity and core competencies of the social service workforce (professional and para-professional), and appropriate caseloads for each cohort within the system. It is also critical to carefully analyze the respective roles and capacity of the para-social workforce, statutory social welfare workers, and project staff (where the system is developed and supported within a project), and to ensure that clear competency frameworks, mentorship, and supervisory systems are in place, and that the systems reflect and link with one another. Each cadre within the social welfare workforce needs the skills and capacity both to fill its role and to ensure the child protection response is managed professionally and confidentially at each step within the case management process, mitigating risks to children and families.

STRENGTHENING THE HIV LENS WITHIN OVC CASE MANAGEMENT SYSTEMS

Case management processes developed within OVC programs must be responsive to HIV-affected children and families and adapted to ensure that they are able to effectively identify, assess, plan for, and monitor an individualized case plan that reflects both the strengths and the needs of the child and household. The case management process of OVC programs should ensure strong linkages with and consistent access to HIV testing, care and treatment programs, health facilities, community clinics, and PMTCT outreach centers. OVC programs, including those documented in the three case studies, are taking the steps outlined below to ensure the case management system is HIV-sensitive.¹⁶

The first step to providing HIV sensitive case management is ensuring an OVC project is effectively identifying HIV-affected children and families. To improve targeting, both **SCORE** and **Yekokeb Berhan** projects increasingly coordinated with clinics, hospital facilities, and other HIV care and treatment programs and PLHIV groups to prioritize HIV-affected and at-risk children and families for enrollment. For project staff and community case workers to provide appropriate care, additional HIV sensitization and basic training may be required to ensure all those working with children and families understand HIV infection and treatment concepts, screening for HIV risk factors, the HIV testing process, adherence,

14 In the three programs the terms “household” and “family” were used, sometimes interchangeably.

15 Ministry of Public Service, Labour and Social Welfare (2015b). Operations Manual for the National Case Management System for Welfare and Protection of Children in Zimbabwe.

16 These recommendations are adapted from the 4Children HTS Operational Considerations draft dated March 15, 2016.

and support strategies and monitoring. Community case workers also need training on all aspects of confidentiality consent and disclosure, including relevant legal and policy frameworks (especially as they apply to children and adolescents).¹⁷ This training could better prepare staff to encourage HIV testing and counseling and provide accurate information and advice to clients.

In addition to more focused targeting and identification protocol and additional training for project staff and case workers, it is also important for OVC projects to coordinate closely with HIV care and treatment providers and to establish formal networks when feasible. Stronger partnerships between health and social welfare systems help to support bi-directional referrals, contract tracing, and defaulter follow-up. Such partnerships improve both social welfare and health outcomes by helping OVC programs to enroll HIV-affected children and families, and helping health/HIV programs reach HIV-positive children and families who are undiagnosed and/or not accessing health service or adhering to treatment. These partnerships can be formalized by developing Memoranda of Understanding (MOU) between OVC implementing partners, clinical partners, and health facilities outlining the roles and responsibilities of both programs with regard to all phases of the HIV services continuum.¹⁸ They can also be supported by positioning clinic-community coordinators at clinics and within OVC programs to coordinate case management and referrals between the health facilities and OVC programs.

These recommendations are intended to help optimize an existing case management system to better serve HIV-affected children and families, and at the same time contribute to achieving the 90-90-90 goal. Different types of adaptations or additional coordination mechanisms might be required to meet different sets of programming objectives (e.g., alternative care panels might be central to the success of a case management system supporting family reintegration, but less relevant to OVC programming). If a case management system is sufficiently robust, these adaptations can be integrated without altering the central Standard Operating Procedures or roles and functions of social service workers supporting case management. The same recommendations can also be adapted to statutory case management systems in high-prevalence contexts (e.g., the Zimbabwe NCMS manages HIV care and testing referrals), although statutory social welfare systems have a broader child protection mandate.

UTILIZING THE THREE PATHWAYS OUT OF OVC PROGRAMMING FOR IMPROVED CASE MANAGEMENT PLANNING

While the goal of case management in OVC programming is ultimately, case plan achievement, (described in the three case studies and previously as graduation or case closure) the reality is that children and families also exit OVC programs via transfer to other programs or through attrition. Lack of clarity between these three pathways out of OVC programming generated some confusion around graduation standards in some of the programs as all children exiting the program were initially categorized as “graduated.” Identifying the

three possible pathways out of OVC programming—case plan achievement, transfer, and attrition—also provides a clear framework from which OVC programs can set program priorities and related benchmarks. Understanding and working toward a more consistent understanding of the different pathways out of OVC programming will help OVC programs in developing appropriate SOPs and tools to support the process. As the sector’s understanding of how to define, measure, and actively engage children and families in identifying and working toward achieving the identified goals of the case plan and of the OVC program develops, relevant tools to support this process, lessons learned in that effort, and documented outcomes should be shared.¹⁹

Conclusion: The case for contextualizing and institutionalizing a case management process within OVC programs

While the three case management case studies help to illustrate promising practices as well as challenges across different contexts, these exact case management systems may not be replicable in new OVC programs or within different contexts. Even in cases where the tools and standard operating procedures are of high quality and have worked well in other projects, contextualization and adaptation are critical to the success of a case management system. OVC programs looking to develop and integrate case management systems into their programs should strongly consider undertaking a consultative process in collaboration with government, other PEPFAR-funded initiatives, and relevant stakeholders to ensure the case management system both meets the immediate project needs and is designed to work within the larger social service system. Case management within OVC programs should also ensure strong linkages with statutory case management systems such as those used for child protection.

Case management is most effective when standard policies and protocols are in place at every level: project, district, and national, allowing projects operating in the same country, districts, and with similar populations to coordinate, refer service delivery, and provide targeted support to households. In many ways, the process used to build consensus and establish these mechanisms is far more critical and important for uptake and acceptance and the functioning of the system, than the specific details of the case management tools and standard operating procedures themselves. Given the short-term nature of donor-supported interventions, this approach is critical to build the case for long-term investments in social service systems, and building the mechanisms to ensure the continuity of care and support for vulnerable children and families.

17 USAID PEPFAR. 4Children. OVC-HTS Operational Considerations. DRAFT: 3.15.16.

18 Ibid.

19 USAID, PEPFAR (March 2017). Pathways for Exiting Programs for Children Orphaned or Made Vulnerable by HIV (OVC)

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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.

