



**GOVERNMENT OF UGANDA**

**Ministry of Gender, Labour  
and Social Development**

**CASE MANAGEMENT  
STANDARD OPERATING PROCEDURES FOR  
CHILD PROGRAMMING IN UGANDA**

.....

**2019**

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# Acknowledgments

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Following over one year of partner consultations together with a participatory review of case management guidance and tools as stipulated under the National orphans and vulnerable children (OVC) Management Information System (MIS), I am pleased to present this harmonized case management toolkit, which includes two documents: Case Management Standard Operating Procedures for Child Programming in Uganda and Case Management Tools for Child Programming in Uganda. This toolkit builds on Ugandan experience and lessons identifying, enrolling, supporting, and graduating vulnerable children and families out of program support. It serves to replace existing set of tools for OVC programming. This tool kit will be used alongside the National Handbook for Probation and Social Welfare Officers and the Case Management Handbook for Child Protection, which are both in the process of being updated to reflect this new guidance.

This toolkit reflects the Ministry of Gender, Labour and Social Development's commitment to guide and coordinate the delivery of social care and support services for vulnerable children and families. It includes a set of standardized approaches and tools to ensure that partners, working to empower vulnerable children and families, are guided by common steps, shared tools, and consistent indicators to monitor and measure reduced vulnerability and readiness for graduation. In this way, case management is a vital tool which helps bring to life the social protection goals contained in the Social Development Sector Plan, SDSP 2015/16-2019/20, namely the objective of enhancing the resilience of vulnerable persons for inclusive growth, while also strengthening protection for vulnerable children and families.

It builds on proven, well-known tools with small adaptations to ensure that partners are using the respective case management tools at the right time, with the right people, to coordinate the delivery of the right services to strengthen social protection.

I wish to acknowledge the invaluable contribution of our development partners, institutions and different individuals who participated in the harmonization of the case management toolkit. While MGLSD took the lead in this process, without the generous technical, financial and material support from key stakeholders, the finalized toolkit would not have been possible.

I hope that this harmonized case management package will facilitate and support greater effectiveness, efficiency, and accountability in our support to empower communities.



**Pius Bigirimana**  
**Permanent Secretary**

*Ministry of Gender, Labour and Social Development*

# List of Acronyms

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<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ANC</b>	Antenatal Care
<b>APX</b>	Approximate
<b>ART</b>	Antiretroviral Therapy
<b>CDO</b>	Community Development Officer
<b>CFPU</b>	Child and Family Protection Unit (of Police)
<b>CHEW</b>	Community Health Extension Worker
<b>CM</b>	Case Management
<b>CRS</b>	Catholic Relief Services
<b>CSO</b>	Civil Society Organisation
<b>DPSWO</b>	District Probation and Social Welfare Officer
<b>ECD</b>	Early Childhood Development
<b>eMTCT-</b>	Elimination of Mother to Child Transmission of HIV
<b>FSN-</b>	Food Security and Nutrition
<b>GBV –</b>	Gender Based Violence
<b>HEI -</b>	HIV Exposed Infants
<b>HES -</b>	Household Economic Strengthening
<b>HH</b>	Household
<b>HIV</b>	Human Immunodeficiency Virus
<b>HVAT</b>	Household Vulnerability Assessment Tool
<b>HVPT</b>	Household Vulnerability Prioritisation Tool
<b>HWSS -</b>	Health Water Sanitation and Shelter
<b>IGA -</b>	Income Generating Activities
<b>IP</b>	Implementing Partner
<b>LC</b>	Local Council
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MGLSD</b>	Ministry of Gender, Labour and Social Development
<b>MOU</b>	Memorandum of Understanding
<b>MUAC</b>	Mid-Upper Arm Circumference
<b>NIN</b>	National Identification Number
<b>NSPPI</b>	National Strategic Programme Plan of Interventions for Orphans and other Vulnerable Children
<b>OVC</b>	Orphans and other Vulnerable Children
<b>OVC MIS</b>	Orphans and other Vulnerable Children Management Information System
<b>PEP -</b>	Post Exposure Prophylaxis
<b>PEPFAR</b>	United States President's Emergency Plan for AIDS Relief

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<b>PrEP –</b>	Pre-Exposure Prophylaxis
<b>PMTCT</b>	Prevention of Mother-to-Child Transmission (of HIV)
<b>PSWO</b>	Probation and Social Welfare Officer
<b>SAGE</b>	Social Assistance Grants for Empowerment
<b>SMC</b>	Safe Male Circumcision
<b>SILC</b>	Savings and Internal Lending Communities
<b>SIMS</b>	Site Improvement Monitoring System
<b>SOCY</b>	Sustainable Outcomes for Children and Youth (SOCY)
<b>SOPs</b>	Standard Operating Procedures
<b>UNCRC</b>	United Nations Convention on the Rights of the Child – 1989
<b>UNICEF</b>	United Nations Children’s Fund
<b>USAID</b>	United States Agency for International Development
<b>UWEP</b>	Uganda Women Entrepreneurship Programme
<b>VAC</b>	Violence Against Children
<b>VL</b>	Viral Load
<b>VSLA</b>	Village Savings and Loan Association
<b>VMMC</b>	Voluntary Medical Male Circumcision
<b>WHO</b>	World Health Organization
<b>YLP</b>	Youth Livelihood Programme

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# Glossary of Terms

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**ATTRITION:** Attrition within the context of orphan and vulnerable children (OVC) programming is understood as the premature termination of support to a child and/ or household due to circumstances beyond the control of the programme. Attrition occurs when the child and/or household requests to no longer participate in the given OVC programme, the programme is unable to locate the child and/or household, or the child dies.

**CASE:** Is an instance of a particular situation or set of circumstances related to any concern for the needs, abuses and absence of interventions experienced by individuals, households, families or communities that requires an individual, a single or multiple sectors to coordinate their plans; policies; human, financial and material resources; or their programmes to deliver a variety of services to the affected child, children or several household members to avoid gaps and overlaps.

**CASE MANAGEMENT:** In the context of OVC programming, case management is the process of identifying, assessing, planning, referring and tracking referrals, and monitoring the delivery of services in a timely, context-sensitive, individualized, and family-centred manner to achieve a specific goal (e.g., child protection and well-being). It is a collaborative process to identify individuals vulnerable to certain risks, assess their needs and strengths to ensure that their rights are being met, set goals in a participatory manner with the client, provide direct or referral services, follow up, evaluate progress, and close the case when the goals have been met.

**CASE PLAN:** A case plan is a document used by Case Workers to outline step-by-step actions that will be taken to meet the goals of the household and the programme. The case plan also includes information such as who is responsible for each step and the timeline for when actions will take place.

**CASE PLAN ACHIEVEMENT (ALSO REFERRED TO AS GRADUATION):** Case plan achievement is recognized as the point when all members of a household have achieved both the goals of the OVC programme, as outlined in the graduation benchmarks, and the goals identified by the household and outlined in the case plan.

**CASE WORKER:** A Case Worker is an individual working at the frontline or the community level who is responsible for conducting direct case management actions with the child and/or household.

**CHILD:** A child is defined as any person under the age of 18 years, in accordance with the United Nations Convention on the Rights of the Child, Article 2 of the African Charter on the Rights and Welfare of the Child, and Article 257 (1) (c) of the 1995 Constitution of Uganda.

**CHILD ABUSE:** Child abuse is doing something or failing to do something that results in harm to a child or puts a child at risk of harm. Child abuse can be physical, sexual, emotional or mental. Neglect or not providing for a child's needs is also a form of abuse.

**CHILD LABOUR:** Child labour is work that deprives children of their childhood, their potential, and/or their dignity; is harmful to physical and mental development; and/or interferes with schooling.

**CHILD PARTICIPATION:** Child participation is the informed and willing involvement of all children, including the most marginalized and those of different ages and abilities, in any matter concerning them directly or indirectly, in accordance with Article 12 of the United Nations Convention on the Rights of the Child.

**CHILD PROTECTION:** Child protection measures are those taken to prevent and respond to all forms of abuse, neglect, exploitation of, and violence against children and their rights.

**CHILD PROTECTION SYSTEM:** Child protection systems seek to address the full spectrum of risks to child protection that children and their households can face and comprise the related set of laws, policies, regulations, and services across all social sectors, particularly social welfare, education, health, security, and justice.

**CHILD RIGHTS:** Child rights are the inherent, fundamental entitlements and freedoms of children, which they have by virtue of being human. Child rights are fully defined in the United Nations Convention on the Rights of the Child to which Uganda is a signatory.

**CHILDREN IN CONFLICT WITH THE LAW:** Refers to children whose actions result in a criminal law being broken and hence are exposed to criminal justice process. They include children suspected or accused of committing an offence

**CHILDREN IN CONTACT WITH THE LAW:** refers to child victims of various forms of abuse, neglect,



violence and exploitations as well as children forced into crime and child witness. They include child victims, witnesses and children of incarcerated mothers.

**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 programmes at the community level, and is the primary linkage to social welfare services at the community level.

**FAMILY:** Family can be defined as a basic unit of existence consisting of one or more parents and their offspring and close relations, which provides a setting for social and economic interaction, as well as the transmission of values and protection. In the context of OVC programming, families may vary in constitution and include those that are headed by a child, an elderly caregiver, or a single parent, amongst others.

**FOOD INSECURITY:** Food insecurity is distinguished in two ways: chronic (a long-term or persistent inability to meet minimum food consumption requirements) and transitory (a short-term or temporary food deficit).

**FOOD SECURITY:** Food security is a situation where at all times, individuals, households, and communities have adequate and nutritious food for their well-being and healthy growth.

**GRADUATION (ALSO REFERRED TO AS CASE PLAN ACHIEVEMENT):** Graduation is recognized as the point when all members of a household have achieved both the goals of the OVC programme, as outlined in the graduation benchmarks, and the goals identified by the household and outlined in the case plan. Graduation in OVC programming can be understood as the defined and measurable stage when households have reached a level of resiliency to meet the developmental needs of the children in their care. The concept of graduation also relates to the capacity of the members in the household to meet the goals identified in the case plan.

**HOUSEHOLD:** A household is a group of people who normally live and eat together in one spatial unit and share domestic functions and activities.

**INFORMED ASSENT:** Informed assent is the

expressed willingness to participate in services or provide information. For younger children who are by definition too young to give informed consent, but who are old enough to understand and agree to participate in services or provide information, the child's informed assent is sought. Informed assent must be clearly documented by the person to whom the child has provided informed assent.

**INFORMED CONSENT:** Informed consent is the voluntary agreement of an individual who has the legal capacity to give permission. To provide informed consent, the individual must have the capacity and maturity to know about and understand the services being offered or information being requested and how this information will be used.

**INSPIRE STRATEGY:** Standing for Implementation and enforcement of laws, Norms and values, Safe environments, Parent and caregiver support, Income and economic strengthening, Response and support services, and Education and life skills. The INSPIRE strategy was developed by the World Health Organization to end violence against children.

**ORPHAN:** An orphan is a child who has lost one or both parents.

**PARENTS:** Parents are defined as persons with parental authority or responsibility. Parenting refers to all the roles undertaken by parents, or others acting in loco parentis, in caring for, raising, and protecting children. Within OVC programming, the term "caregiver" is also commonly used to refer to those individuals caring for, raising, and protecting children.

**PRIMARY CAREGIVER:** A primary caregiver is the person recognized by the state as being responsible for the care and upbringing of a child.

**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 a district.

**PSYCHOSOCIAL SUPPORT:** Psychosocial support is assistance that helps individuals and communities heal the psychological wounds and rebuild social structures after an emergency or critical event. Psychosocial support can help people become active survivors rather than passive victims.

**SOCIAL PROTECTION:** Social protection is a set of public policies, programmes, and systems that help poor and vulnerable individuals and households reduce their economic and social vulnerabilities, improve their

ability to cope with risks and shocks, and enhance their human rights and social and economic status.

**TRANSFER:** Transfer is the process of supporting the movement of a child and/or household from active participation in a given programme to another source of case management support. Other sources of case management support may include government support, community support, or support provided by one programme but funded by another programme. Transfer could occur for various reasons including the child's age, the geographic scope of the programme providing services, or the ending of a programme that was previously providing services to a child or household.

**UGANDA CASE PLAN ACHIEVEMENT BENCHMARKS / INDICATORS FOR OVC PROGRAMMING (ALSO KNOWN AS GRADUATION BENCHMARKS):** These are indicators that reflect that a household has increased resiliency and is able to provide for basic needs, including the health and protection of the children in its care. These benchmarks/indicators also capture critical elements that result in improved outcomes for children, including improved well-being. The indicators for OVC programmes are aligned to the four priority areas of the National Child Policy, which represent

the holistic nature of OVC needs: survival and health; economic stability and security; care and protection; and education and development.

**VIOLENCE AGAINST CHILDREN:** Violence against children is any form of physical, emotional, or mental injury or abuse, neglect, maltreatment, or exploitation, including sexual abuse. It comprises the intentional use of physical force or power, threatened or actual, against an individual, which may result in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.

**VULNERABILITY:** Vulnerability is the state of being, or the likelihood of being, in a risky situation, where a person is likely to suffer significant physical, emotional, or mental harm, which may result in their human rights not being fulfilled.

**VULNERABLE CHILD:** A vulnerable child is one who is suffering from, or who is likely to suffer from, any form of abuse or deprivation and is therefore in need of care and protection.

## BACKGROUND TO HARMONISATION OF CASE MANAGEMENT SOPS, TOOLS, AND TRAINING MATERIALS

In 2002, the Government of Uganda undertook a situation analysis of Orphans and other Vulnerable Children (OVC) for the very first time. The analysis revealed that besides orphans, there were other vulnerable children in the country who equally needed external support to improve their well-being. As a result, in 2004, the Government launched an OVC policy and its five-year National Strategic Programme Plan of Interventions (NSPPI [2004/5–2009/10]). The second NSPPI was launched for the period 2010/11–2015/16. Both the OVC policy and its two strategic plans required that data generated from OVC case management (CM) processes be captured within the Orphans and Vulnerable Children Management Information System (OVCMIS) through regular data collection and reporting by both state and nonstate service providers. The OVC policy 2004 has been revised to the National Child Policy, in line with the East African Community policy framework. In 2016, the Ministry of Gender, Labour and Social Development (MGLSD) developed a CM handbook and trainers' manual to guide and harmonise CM for OVC programming in the country. However, in July 2017, a meeting between the MGLSD and the chiefs of party/ project directors of different implementing partners (IPs) involved in OVC programming agreed that the CM tools, standard operating procedures (SOPs), and training materials being used by both the Government and IPs were not harmonised, not meeting global CM and social work practice standards, and were not responsive to HIV/ AIDS concerns. Based on this meeting, an assessment was recommended of both the MGLSD's and the IPs' CM tools, SOPs, and training materials for OVC programming.

The assessment was undertaken by 4Children with support from the United States Agency for International Development/United States President's Emergency Plan for AIDS Relief (USAID/PEPFAR), and the results were presented to both the MGLSD and the IPs in September 2017. The assessment found that the MGLSD's CM toolkit was not family strengths-based; it lacked core or foundational social work principles for CM; it was not HIV-responsive; and it lacked SOPs on how the users could complete the tools. The assessment also found that the MGLSD's toolkit was focused on improving the user's foundational knowledge of children's rights, child protection legal and policy frameworks, and the roles of the different duty bearers. The concept of case plan achievement (previously known as graduation), including its definition, was not well integrated into the MGLSD's toolkit, nor were the relevant benchmarks or indicators for case plan

achievement, transfer, or attrition.

The assessment also found that though most IPs used the MGLSD's CM package in OVC programming, many had developed additional tools to address the gaps in the MGLSD's tools, especially in monitoring the case plan achievement/graduation of beneficiaries. In addition, the IP CM toolkits did not have detailed SOPs to guide the engagement of children and caregivers in CM steps or to assess the needs and build on the families' strengths and resources to address their own problems. The assessment found that the IPs' toolkits lacked step-by-step SOPs and training materials on how to complete and analyse the CM tools.

*The assessment also found that the MGLSD's toolkit was focused on improving the user's foundational knowledge of children's rights, child protection legal and policy frameworks, and the roles of the different duty bearers.*

The assessment also found that some IPs did not use the MGLSD's CM package at all and instead had developed their own tools and training materials. Except for the inclusion of the government logo on the tools and forms that were used, these IP tools reflected the key Government of Uganda legal, policy, and regulatory frameworks in only a limited way. Both the MGLSD and IP toolkits that were assessed lacked adequate guidance on communicating with children in an age-appropriate manner and depending upon the child's evolving capacities during CM.

In response to the assessment findings, in December 2017 and January and February 2018, the MGLSD convened a series of consultative meetings with key OVC programming stakeholders on the harmonisation of CM tools, SOPs, and training materials, which resulted in the development of the first and second drafts of the harmonised CM tools and SOPs. It was these tools and SOPs that the MGLSD recommended for pretesting in 14 districts by nine USG (United States Government) and non-USG-supported OVC programming IPs. The pretest results were incorporated into this final harmonised toolkit, which includes SOPs, tools, and training materials intended for use by both Government partners and IPs involved in service provision to vulnerable children across the country.

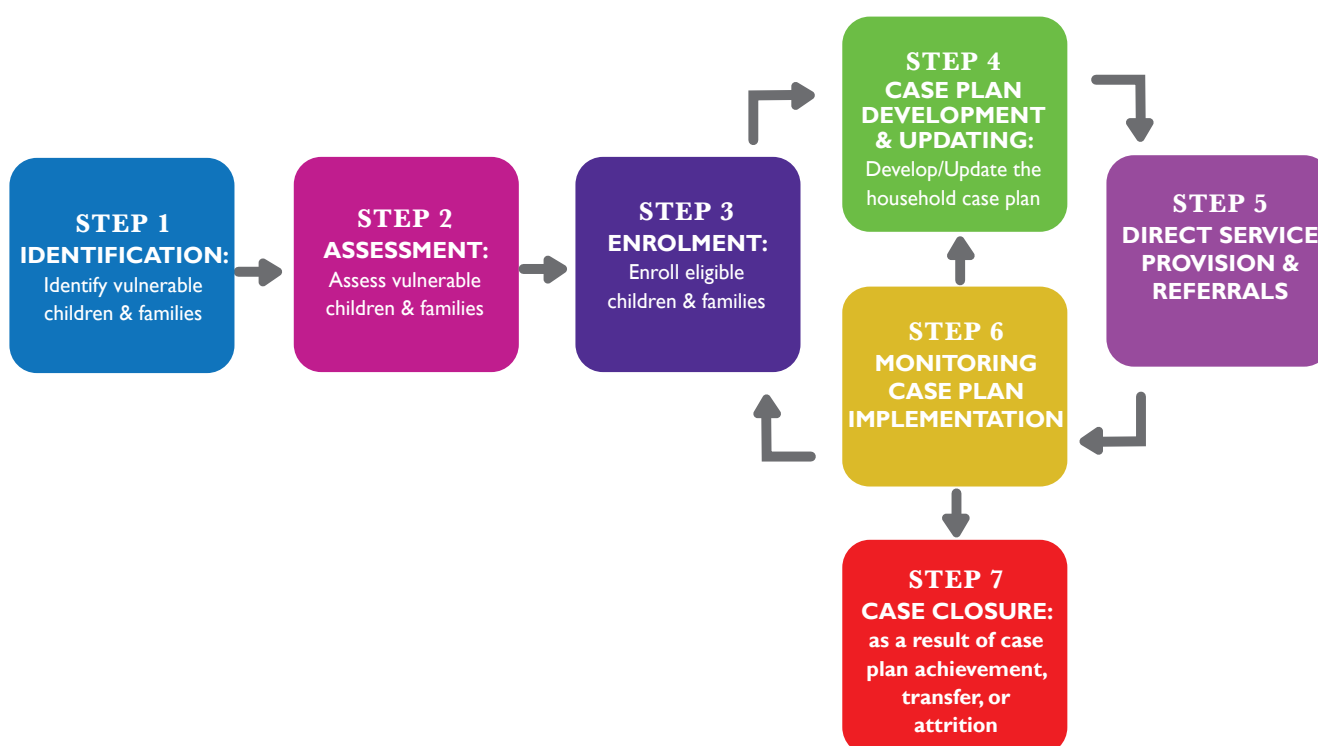
## THE OBJECTIVES FOR HARMONISING CM IN OVC PROGRAMMING ARE:

- To provide clear and practical guidance on how to understand and utilize CM indicators
- To engrain strength-based approaches in all the seven steps of CM
- To provide guidance on how to involve and engage children and their caregivers in every step of the case management process for their well-being.
- To put in place standardized monitoring indicators for case plan achievement and case closure
- To integrate core and foundational social work principles into the OVC CM approach.
- To engender HIV and AIDS responsiveness in case management for OVC Programming

## INTRODUCTION TO THE CASE MANAGEMENT PROCESS

CM for OVC programming includes the following seven steps (see Figure 1: ) identify vulnerable children and households (using pre-established targeting or eligibility criteria), 2) assess eligible children and households, 3) enroll vulnerable children and households meeting enrolment criteria, 4) develop (or update) a household case plan, 5) implement the case plan (including provision of direct services or referrals to other services), 6) monitor progress towards case plan achievement in a timely, context-sensitive, individualised, and family-centred manner to achieve specific goals, and 7) achieve case closure as a result of case plan achievement, transfer, or attrition using the related tools and SOPs.

**Figure 1. Steps of Case Management**



At identification (**Step 1**), households are flagged as vulnerable, assessed, and ranked for enrolment using the OVC Pre-Identification and Registration Form and the Household Vulnerability Prioritization Tool (HVPT). These two tools are used by community leaders and volunteers to identify children in their community whom they consider vulnerable, as well as the areas in which they are vulnerable and in which they may need additional support from external interventions.

Once households or individuals are identified as vulnerable and eligible for enrolment, the Case Worker or community development officer (CDO) visits the identified vulnerable households and conducts an assessment of the strengths and needs of the household and the challenges it faces (**Step 2**).

After assessment, households or individuals found to meet the criteria for enrolment in projects or government services are required to sign an enrolment form. This form allows project staff or government officers to engage with the members of the household in managing their needs and resources to deal with their problems (**Step 3**).

Once the households or individuals are enrolled in project or government services, they are supported by a Case Worker in developing a case plan (**Step 4**). This case plan states the well-being goals they wish to achieve across the four priority areas of the National Child Policy, as well as actions that the household and service provider will undertake to address the identified needs and challenges and proceed towards the stated well-being goals. This process recognizes and builds on the capacities and strengths of the households to manage their own challenges.

The next CM step is the direct delivery or referral to services to address the identified needs as per the case plan (**Step 5**). These services are typically provided by IPs or government service providers.

Monitoring the outcomes of the services delivered to the enrolled beneficiaries is **Step 6** of the CM process. This participatory process involves beneficiaries reporting on their own progress and accomplishments using a copy of the case plan left by the Case Worker. Case Workers visit the families with a copy of the case plan to review the set goals, as well as to assess individual HIV status, enrolment in treatment, and viral load suppression. In addition to regular home visits, households are monitored on a quarterly basis using the HVAT 007A and AVAT 007B Tools.

**Step 7**, which is case plan achievement (previously known as graduation), is broadly understood as the point at which a child and his/her household can meet their basic needs and are able to address their challenges. By meeting the predetermined benchmarks/indicators in the priority areas of survival and health; economic stability and security; care and protection; and education and development spelt out in the National Child Policy, the child and household no longer require the interventions offered by an IP project or direct government programme. The CDO or Case Worker working with the household organises a ceremony for the individual/household and other graduating households in coordination with local leadership to celebrate their achievements. At the graduation ceremony, household members are expected to share their testimony and accomplishments and encourage other households to continue working to achieve their goals. After the ceremony, the case file for the household is officially closed.

*The CDO or Case worker working with the household organises a ceremony for the individual/household and other graduating households in coordination with local leadership to celebrate their achievements.*



## GUIDING PRINCIPLES OF CASE MANAGEMENT

The principles of CM are informed by and reflect many of the core values and principles of social work, as well as international and domestic rights-based legal and policy frameworks. When implementing a CM process within an OVC programme, the following principles should guide the practice of all actors engaged in the process and should be reflected in all decisions made about a case:

- **Do no harm.** Those working within the CM process should give thoughtful consideration to how their actions will affect the children and households being served.
- **Prioritize the best interests of the child.** Within OVC programming, it is good practice to have all decisions and related actions involving the child's welfare be guided by the best interests of the child. This practice also reflects international and national rights-based legal and policy frameworks.
- **Do not discriminate.** All individuals regardless of race, sex, religion, sexual orientation, or health status should be treated with respect, recognizing the dignity and worth inherent in all humans. All actors involved in the CM process should practice respect for cultural diversity.
- **Provide client-centred services.** Case Workers should actively engage the children and caregivers in all aspects of CM and should tailor services, via a case plan, to meet their unique needs and goals. Finding age-appropriate ways for children to actively participate in the process and in the decisions that affect their lives is not only good CM practice, it is also a right. (See Job Aid on Engaging Children, below, for more ideas how to actively engage children.) Children's participation in the process should be determined based on their age and evolving capacities. Self-determination (i.e., the idea that clients are best placed to make their own decisions about what is best for them) should also be promoted whenever possible.
- **Use a strengths-based perspective.** Instead of focusing on needs and deficits, actors within the CM process should focus on clients' strengths and abilities. This strengths-based approach builds on the resilience and potential for growth inherent within each individual.
- **Be goal-oriented.** The goal of CM is case plan achievement. Actions should be directed towards meeting this goal.
- **Foster trust and privacy within the client/ Case Worker relationship.** The alliance between clients and Case Workers is critical for clients to achieve their goals. Case Workers should be sensitive to issues that may lead to stigma (e.g., HIV status or being a single mother or child bride) and should respect their privileged relationship with clients by keeping all information confidential.
- **Collaborate with others.** A Case Worker should not work in isolation. Proactive collaboration with other service providers, community volunteers, and Case Managers, as well as members of other disciplines and organizations, is integral to the success of the CM process.
- **Recognize that children and households are part of a larger community.** Children and their caregivers live within communities that are positioned within regions, which exist within countries that have unique cultures and customs. Case Workers should understand the communities in which they work and should consider how the community as a whole may be leveraged to meet the needs of children and households made vulnerable by HIV/AIDS.

## STRUCTURE OF THE TOOLKIT

This harmonised CM toolkit includes standard operating procedures describing how each step of the CM process should be implemented, tools or forms that should be used for CM, and additional guidance that must be taken into account by actors involved in CM.

The various tools used for CM are listed below as part of the step each supports. The exact step on which each tool can be found in the toolkit is provided below.

### STEP 1 – IDENTIFICATION

- **Tool 1:** OVC Pre-Identification and Registration Form (OVCMIS FORM 005)
- **Tool 2:** Household Vulnerability Prioritization Tool (HVPT) (OVCMIS FORM 006)

### STEP 2 – ASSESSMENT

- **Tool 1:** Household Vulnerability Assessment Tool (HVAT) (OVCMIS FORM 007A)
- **Tool 2:** Adolescent Vulnerability Assessment Tool (AVAT) for Adolescents Aged 12–17 years (OVCMIS FORM 007B)

### STEP 3 – ENROLMENT

- **Tool 1:** Household Enrolment Form (OVCMIS FORM 008)
- **Tool 2:** Child Care and Protection Case Record Form (OVCMIS FORM 004A)
- **Tool 3:** Integrated OVC Service Register (OVCMIS FORM 004B)

### STEP 4 – CASE PLAN DEVELOPMENT AND UPDATING

- **Tool 1:** Case planning with caregivers, children (8–17 years and adolescents 12–17 years) (OVCMIS FORM 0012A)
- **Tool 2:** Summary of Key Priority Actions to Share with the Household / Adolescents (OVCMIS FORM 0012B)

### STEP 5 – DIRECT SERVICE PROVISION AND REFERRAL

- **Tool 1:** Service Provision and Referral Form (OVCMIS FORM 009)
- **Tool 2:** Case Conference Form (OVCMIS FORM 013)

### STEP 6 – MONITORING

- **Tool 1:** Ongoing Monitoring Form (OVCMIS FORM 014A)
- **Tool 2:** OVC Household home visit Form (OVCMIS FORM 014B)
- **Tool 3:** Quarterly Report (OVCMIS FORM 100)
- **Tool 4:** Household Vulnerability Assessment Tool (HVAT) (OVCMIS FORM 007A)
- **Tool 5:** Adolescent Vulnerability Assessment Tool (AVAT) for Adolescents Aged 12–17 years (OVCMIS FORM 007B)
- **SOP:** Guiding Questions for Preparing a Household for Case Plan Achievement (or Service Exit)

### STEP 7 – CASE CLOSURE AS A RESULT OF CASE PLAN ACHIEVEMENT, TRANSFER, OR ATTRITION

- **Tool 1:** Case Transfer Plan (OVCMIS FORM 016)
- **Tool 2:** Case Closure Checklist (OVCMIS FORM 017)
- **SOP:** For Managing Attrition



# STEP 1



## IDENTIFICATION

1





## CM STEP 1 – STANDARD OPERATING PROCEDURE FOR IDENTIFICATION

### WHAT:

Within OVC programming, identification is the process of distinguishing vulnerable children and their households that need external support from OVC programmes or services in order to become resilient and progress along a path towards sustainable self-well-being. These children include those who are orphaned, infected, or made vulnerable by HIV/AIDS and other adversities. Identification for enrolment into a government or other OVC programmes involves two steps: Pre-identification - to identify vulnerable children or households in the target area, followed by prioritization of those who should be considered most vulnerable and meeting the enrolment criteria in either government or IP OVC programs.

### TOOLS:



CM Step 1 **Tool 1:** OVC Pre-Identification and Registration Form (OVCMIS FORM 005)

CM Step 1 **Tool 2:** Household Vulnerability Prioritization Tool (HVPT) (OVCMIS FORM 006)

### WHO FACILITATES:

Village leaders with the support of project staff facilitate the pre-identification process. Prioritization is done by community-level Case workers who have been trained in administering the HVPT and work under the supervision or guidance of the Case Manager in collaboration with the sub-county CDO. Community-level workers to be trained in administering the Pre-Identification tools can include para-social workers, VHTs, Local Council members, community resource personnel, or other community members that demonstrate social engagement, an interest in helping vulnerable children, and adequate in literacy and numeracy skills. Other Local Government staff who have been trained to administer the tool, can also be directly engaged in OVC identification activities. The Pre-identification and Registration tool should be filled before the HVPT is used. All Households visited during Pre-identification should have at least one child aged 0-17 years.

The HVPT will be filled in by the program Case worker and reviewed or approved by the IP Case Manager. Within government the HVPT will be filled by the CDO and reviewed by the Senior Assistant Secretary (Sub-County Chief) or by the PSWO / DCDO for enrolment of vulnerable households or children living without an adult care giver into Government social protection programmes. If identified in the households the following should be referred immediately: Abuse, serious illness without treatment and visibly malnourished children.

### WHO PARTICIPATES:

Children and parents/caregivers (their household) listed by village leaders on the OVC Pre-Identification and Registration Form as potentially vulnerable and in need of OVC programme services participate. These children typically include: children living with or affected by HIV, children who have lost one or both parents to HIV/AIDS, children living with HIV+ parents/caregivers, children living outside of family care, children out of school, street-connected children, adolescent girls living in high-prevalence HIV environments, children living in child-headed households, children living in households headed by elderly persons, children in conflict or in contact with the law, refugee children and children with disabilities.

### HOW:

#### The OVC programme staff should:

1. At the time of project initiation and beneficiary identification, contact the local (district or sub-county) government authorities, starting with the chief administrative officer (CAO), the district community development officer (DCDO), the PSWO, and the sub-county CDOs to inform and involve them in the process. This is an important and fundamental step: the local government is responsible for the well-being of their communities, is there to coordinate services of IPs, and can help in identifying and facilitating access to village leaders and referral services to enable a holistic approach to child and household well-being.
2. Work with village leaders to list children and orphans in the target area who are considered to be vulnerable (and their households if they live in a household) on the OVC Pre-Identification and Registration Form. This is the Pre-identification step. Local village leaders are engaged in this process because of their familiarity with

#### WAYS TO BUILD RAPPORT

Rapport means a good relationship. In good relationships, people communicate comfortably and understand each other's feelings or ideas. Case workers should establish rapport with children and other household members from the beginning of their relationship because it builds trust.

#### RAPPORT- BUILDING TIPS FOR CASE WORKERS:

- Greet members of the household warmly and introduce yourself to each member in a culturally appropriate manner.
- Ask the head of the household to introduce the members of their family.
- Get to know the members of the household before beginning to discuss the programme. This builds trust.
- Make eye contact and position your body in the direction of and at the same level as the person who is talking (e.g., sit on the floor if the person speaking is sitting on the floor).

the households and OVC in their village. These OVC are identified: a) through referrals from health facilities, schools, social services, police, or other institutions; b) from a list of households generated by community leaders using the four factor criteria (orphanhood, disability, being out of school, and chronic illness); or c) through a community mapping process managed by the OVC programme.

3. Administer the Household Vulnerability Prioritization Tool to OVC and households that have been pre-identified as vulnerable and listed on the OVC Pre-Identification and Registration Form. This is the prioritization step: it is for identifying those HHs or unaccompanied children who are most vulnerable and should be considered for assessment of their needs and strengths by Priority Area and their eligibility for enrolment into IP or government OVC or social protection programs.

### **Caution with regard to administering the tools and the use and storage of data**

The HVPT should be administered to the household or to the unaccompanied child out of earshot of other community members, workers, and minors to protect the confidentiality of respondents. The questions should be read as stated and should not be modified in any way that changes the meaning or intent of the question. No additional criteria should be added and none should be deleted, as this is a national tool.

Below, the process for prioritizing households is described. This is the appropriate way to use the information collected in the HVPT. HVPT data may not be “analyzed” in any other way or for other purposes. When additional analyses occur, the resulting information can be misused. The main purpose of this tool is to assist programmes in prioritizing households for enrolment into support programmes or services.

All forms should be stored in a locked cabinet and protected according to national data protection laws and regulations. In addition, the database storing this information should be password-protected, with access allowed only to designated officers.

### **For prioritization based on HVPT results, OVC programme staff members should:**

1. Gather all of the HVPTs from the designated officer who collected them for a given community. Staff members should enter the information in a simple, pre-programmed Excel database provided to them. As staff enter data, they should check that any areas marked “referral needed” are appropriately followed up and that a referral is provided. The Excel database will generate a list of households using a three-step prioritization process. However, it is important to understand how this process works should the designated officer experience challenges with the database and need to do the process manually. For more detail on the three-step prioritization process and specific instructions for data entry and database use, please see the Uganda Household Vulnerability Prioritization Toolkit.
2. Based on the findings of the HVPT, work in coordination with local government authorities to assess the most vulnerable families for enrolment in the OVC programme.
3. Assign eligible households to community-level Case Workers (trained Para-Social Workers or other trained paraprofessionals engaged by the project). It is recommended to assign Case Worker/client pairs per geographic location to reduce the cost and time burden of transportation.

### **For reporting to the district government, OVC programme staff members should:**

1. Assess households for the services delivered and report the necessary indicators to the district for entry into the OVC Management Information System (OVCMIS) using the approved Ministry tool (OVCMIS Form 100) under step 6 of the toolkit.
2. Provide to the CDO in the project area the list of the households that have been enrolled, with the key vulnerabilities to be addressed, as well as another list of all households for which a referral was needed. The Excel database within the OVCMIS will automatically generate these lists, which can then be printed by the PSWO and handed over to the respective Case Worker. The parish chiefs, trained Case Workers or Case Manager should complete this step.

### **The CDO will then:**

1. Verify the list of enrolled beneficiaries against the existing OVCMIS database of all other service providers already operating in the local area. The CDO will confirm that the households or individual children are not already enrolled or receiving similar services and if not, will approve them for enrolment into governments or IP programmes.



## CM STEP 1 – ADDITIONAL GUIDANCE DATA PROTECTION PROTOCOLS<sup>1</sup>

### CONFIDENTIALITY, DOCUMENTATION, RECORD FILING, AND INFORMATION SHARING

Data protection relates to the protection of all personal data collected, either through individual discussions or the receipt of secondary data. Agencies involved in CM must develop data protection protocols based on the principles of confidentiality and “need to know,”<sup>2</sup> with the ultimate aim of safeguarding the best interests of the child. Data protection protocols serve as a guide for what information to collect; how the information will be used; and how the information will be stored. All staff involved in the CM process should be aware of the data protection protocols.<sup>3</sup>

#### CONFIDENTIALITY

Data protection protocols are based on the principle of confidentiality. Confidentiality is the preservation of privileged information. The information learned from working with a child or a household is necessary to provide services to that child or household, and it is shared within the development of a helping, trusting relationship. All information concerning children, caregivers, or household members is confidential. This confidentiality means that Case Workers are not permitted to disclose the names or locations of children, caregivers, or household members, or to talk about them in ways that would make their identity known for any other purpose than the provision of services and on a need-to-know basis.

Confidentiality protocols should be based on the understanding that the child/household owns the case information and that only **with the caregiver’s consent and the child’s assent** can the information be shared beyond the CM relationship, unless ordered by an authorised statutory entity such as a court or government department.

**During enrolment, the Case Worker should ensure the caregiver’s consent and the child’s assent is received and documented.** The implications of sharing this information should be fully explained.

Examples of the confidentiality policy and forms for all Case Workers to sign can be found at the end of this additional guidance.

### TIPS FOR ENCOURAGING CHILDREN AND ADOLESCENTS’ PARTICIPATION IN THE CASE MANAGEMENT PROCESS

- When speaking or listening to a child, focus your attention on both what he/she says and does.
- Use simple language. Think about the words you use. Long sentences will confuse children.
- Use a child’s experience to explain things.
- Be friendly and approachable. Never look bored, angry, or worried while a child is talking or be judgmental because this will stop him/her from talking. Maintain eye contact.
- Actively listen and respond to the child. Try to answer his/her questions as honestly as possible.
- Sit at the same level as children.
- Provide adequate space to talk to the child in an appropriate environment—one conducive to participation.
- Assure the child that whatever he/she tells you will be kept confidential.
- Be empathetic—show that you can understand what the child has been feeling (without saying that you are feeling it yourself). Always respect the child or adolescent’s opinions.
- Do not be afraid of silence when the child needs time and space to gather thoughts.
- Do not rush children. Be patient, go at their pace, and allow them to express their emotions.
- Encourage the child by nodding or smiling, but not too often to distract.
- Ask open-ended questions.
- Summarise and clarify regularly what the child has said, making sure that you have understood what the child is trying to say and clarifying what the child knows about the situation.
- Encourage the child or adolescent to find solutions to their problems and identify positive aspects that would help them in finding solutions.

<sup>1</sup> Adapted from: 4Children Uganda. January 2018. *Case Management Standard Operating Procedures (SOPs) for Reintegration of Children in Residential Care into Family Care: Toolkit Keeping Children in Healthy and Protective Families Pilot*; Child Protection Working Group. 2014. *Inter-Agency Guidelines for Case Management & Child Protection*; Government of Namibia Ministry of Gender Equality and Child Welfare. 2017. *Child Protection Case Management Operations Manual*

<sup>2</sup> The term “need to know” describes the limiting of information that is considered sensitive, and sharing it only with those individuals who require the information to provide services to the household and children. Any sensitive and identifying information collected on households and children should only be shared on a need-to-know basis with as few individuals as possible.

<sup>3</sup> Child Protection Working Group. 2014. *Inter-Agency Guidelines for Case Management & Child Protection*.

## DOCUMENTATION AND RECORD-KEEPING

All CM work will be documented following established information management and data protection protocols centred on the **family and child's case file** and described within this document. Documentation includes both written paper records and electronic CM records.

### 1) Case Files

**Individual family case files** should be created for each case and should include documents for each child in the family, with key information presented in a standard, structured way. Individual family case files should include the standard forms and case notes that document each step of the CM process.

As a case progresses, forms and notes should be accurately and thoroughly filled out and stored in the file.

These files should be kept in a **secure location** with restricted access, such as in a **locked cabinet**.

There should be clear and coordinated data collection, storage, and analysis protocols in place.

The retrieval and any other movement of files from the filing cabinet must be documented within a register to ensure that case files can be tracked between government CDOs or PSWOs, Case Workers, supervisors, and monitoring and evaluation (M&E) and programme staff. The staff member retrieving the file should complete a register. Below is an example that can be used.

Client name	Unique identifier	Name of Case Worker requesting the file	Date of retrieving the file	Date of return of the file

*Resilience is defined as the ability of children and their families to deal with, and recover from, adversity and crisis, influenced by individual characteristics and external factors like: diversity of livelihoods, coping mechanisms, life skills such as problem-solving, the ability to seek support, motivation, optimism, faith, perseverance, and resourcefulness.*

When a file is retrieved, it is common practice to place a holder to indicate that it has been retrieved. This can be an empty folder or a card with the name and number of the file that has been retrieved, as well as the name of the person who had removed it.

### 2) Unique Identifier

The case should be assigned a **unique identifier** for confidentiality purposes and the effective tracking of individual cases. The unique identifier should be a code based on an agreed-upon standard format and should not identify the household or child. The format may indicate areas of identification or areas of origin but should guarantee anonymity of all members of the household.

The code should be used to refer to the child's case either verbally, on paper, or electronically (including in Microsoft Word documents, emails, Skype conversations, etc.) in place of any identifiable information, such as National Identification Number (NIN), name, or date of birth.

All files should be stored according to the allocated code.

The unique identifier should be marked on the front of the case file. The name of the family should not be recorded on the front of case files. A unique identifier shall be provided by government or IPs for their internal use.

### 3) Database

Selected information should be entered into the database in a secure and confidential manner. The electronic data should be **password-protected** and the password should be **changed on a regular basis**. Information should be transferred by **encrypted or password-protected files**, whether this transfer is via the Internet or memory sticks (USBs). Memory sticks should be passed by hand between people responsible for the information, and the password-protected file(s) erased immediately after transfer. The file should also be permanently erased from the recycle bin of the computer.

Young children may find it easier to talk through playing games, such as making sad or happy faces, or through pointing at happy or sad pictures. This activity may also help when communicating with a child who has a learning or speech impairment. In such cases, a social worker may want to get assistance from someone with early children development expertise or the child's disability support worker. This request for assistance must be done without breaching confidentiality.

At times, adolescents may not wish to share thoughts or feelings, or even say what has happened, for fear of negative consequences for themselves or others. A child may feel that he/she was responsible if he/she was sexually abused, when out socializing, for example. In such cases, it is important for the social worker to make it clear that he/she is not being judgmental, and that it is okay for teenagers to do what they do. They may be conscious of the consequences of 'getting other people into trouble.' The principle of confidentiality is important here. Some teenagers find it easier to communicate while they are walking together or when they are in a vehicle, as long as others are not around.

**A regular backup system should be in place.** Typically, on-site back-up is done on an external hard drive which is kept locked in a filing cabinet. Ideally, a second off-site back-up in a second location (for example, in the head office) should be set up for secure storage in a pre-defined centralized location. The reason for having an off-site back-up is that the data can be retrieved if the main database becomes damaged. The off-site back-up is often done through electronically sharing the database with the designated receiver as an encrypted, password-protected zip file.

Computers should be fitted with **up-to-date anti-virus software** to avoid corruption and loss of information.

Staff responsible for data entry and management should be **included in all CM-related training and capacity-building activities** to ensure they understand the processes, especially these data protection and confidentiality issues.

## INFORMATION-SHARING PROTOCOLS

As multiple agencies or government departments are working together to address the needs of households and children through the provision of multiple services and referral pathways, it is essential to also develop agreed-upon information-sharing protocols, which define what information about the household and children should be shared, when, and with whom. How this information will be shared—verbally, electronically, or through a paper system—also needs to be defined, with appropriate procedures to ensure that the confidentiality of the household and child is protected and respected at all times.<sup>4</sup>

A confidentiality agreement must be signed when confidential information is being shared amongst multidisciplinary actors participating in an integrated CM effort, such as a case conference. An example of a confidentiality agreement for case conferences can be found at the end of this additional guidance.

## CONFIDENTIALITY POLICY

Confidentiality is the preservation of privileged information. The information learned from working with a household and children is necessary to provide services to the child or household, and it is shared within the development of a helping, trusting relationship. All information concerning children, caregivers, or family members is confidential. This means that you are free to talk about the project generally, and about the programme and your position, but you are not permitted to disclose child, caregiver, or family names, or locations, or to talk about them in ways that would make their identities known.

No information may be released, even to other organizations or agencies, without appropriate authorization and documented consent from children and caregivers. This is a basic component of social work ethics.

You are expected to respect the privacy of children, caregivers, and families and to maintain their personal and household information as confidential. All records dealing with specific children and families must be treated as confidential. General information, policy statements, or statistical material that is not identified with any individual- or family-specific information is not classified as confidential. Staff members are responsible for maintaining the confidentiality of information relating to other staff members and volunteers as well.

Failure to maintain confidentiality may result in termination of employment or other corrective action.

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<sup>4</sup> Child Protection Working Group. 2014. *Inter-Agency Guidelines for Case Management & Child Protection*.

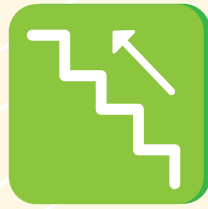
## **CERTIFICATION FOR ABIDING BY THE CONFIDENTIALITY POLICY**

I have read the organization's policy on confidentiality. I agree to abide by the requirements of the policy and to inform my supervisor immediately if I believe any violation (unintentional or otherwise) of the policy has occurred. I understand that violation of this policy will lead to disciplinary action.

**SIGNATURE** \_\_\_\_\_

**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_





# STEP 2



## ASSESSMENT


2

## CM STEP 2 – STANDARD OPERATING PROCEDURE FOR ASSESSMENT

### WHAT:

Assessment is the process of collecting information on the specific needs and strengths of a child and/or household, with the intention of determining the level of vulnerability and informing the development of a case plan to support the child and/or household along a process towards well-being. Based upon the findings of the Household Vulnerability Prioritization Tool used in this Step of the CM process, the assessment should be done by the Case Worker immediately after identification.

### TOOLS:

-  • CM Step 2 **Tool 1:** Household Vulnerability Assessment Tool (HVAT) (OVCMIS FORM 007A)
- CM Step 2 **Tool 2:** Adolescents Vulnerability Assessment Tool (AVAT) (OVCMIS FORM 007B)  
for Adolescents Aged 12–17 years
- CM Step 1 **Tool 2:** Household Vulnerability Prioritization Tool (HVPT) (OVCMIS FORM 006)

### WHO FACILITATES :

The Case Worker (e.g. trained para-social worker) supporting the child and/or the household facilitates, application of the tools with the support of the Case Manager, CDO or PSWO.

### WHO PARTICIPATES:

All members of the household participate.

### HOW:

**Before going to the household, CW in collaboration with the Case Manager / CDO /PSWO should:**

1. Use the information gathered from the **Household Vulnerability Prioritization Tool** to begin filling in the **Household Vulnerability Assessment** tools. Any information that cannot be completed based on the **Household Vulnerability Prioritization Tool** should be left blank and questions regarding that information will be asked during the home visit.
2. The HVAT form 007A and AVAT form 007B are for assessment of households, unaccompanied children and adolescents selected through HVPT or referred to a service provider to ascertain their level of vulnerability and to monitor its progress periodically.

**During the home visit for the assessment of a household, the CW should:**

3. Invite all members of the household to participate in the assessment to identify their unique needs, assets, and strengths.

**For the caregiver(s) living in the household, the CW should:**

4. Explain to the caregivers that he/she will now ask a series of questions that will enable him/her to better understand their lives and develop a case plan that best suits their household's unique needs and strengths. Some of the questions may be sensitive, and the Case Worker should explain that if the caregiver prefers not to answer, he/she may do so at any time. The Case Worker should also be careful to explain that there is no promise of goods or services through the government or programme as part of the assessment step.
5. Ask the caregiver the questions listed on the **Household Vulnerability Assessment Tool** and tick the responses. For adults and children under the age of 12 years with unknown HIV status, the Case Worker should refer for HTS.
6. The assessment tools should be applied on only households that will be supported with social protection, GBV, legal aid, alternative care and disability services. The MUAC tape or Bipedal Edema test should be used to confirm suspected cases of malnutrition among children less than 5 years of age



**For each adolescent aged 12–17years living in the household, the CW should:**

7. Ask the caregiver if he/she agrees to allow the adolescent to answer a series of questions. If the caregiver agrees, the Case Worker and adolescent may choose to move to a location where their responses will not be heard by others. If the caregiver does not agree, the Case Worker should conduct the assessment with the caregiver present, making sure that the adolescent does not have to answer any question that he/she is not comfortable with. The Case Worker should mention this refusal by the caregiver to the Case Worker/Case Manager later.
8. Interview the adolescent separately (if the caregiver agrees) and explain that he/she is going to ask a series of questions to better understand the adolescent's life and develop a case plan that best suits his/her unique needs and strengths. Some of the questions may be sensitive, and the Case Worker should **explain that if the adolescent prefers not to answer, he/she may do so at any time.**
9. Ask the adolescent the questions listed on the **Adolescents Vulnerability Assessment Tool for Adolescents Aged 12–17years** and tick the responses. For adolescents with unknown HIV status, the CW should refer for HTS accordingly.

**For the caregiver(s), children, and adolescents living in the household, the CW should:**

10. Ensure that all members of the household (children, adolescents, and caregivers) have the opportunity to participate in the assessment and that their opinions and priorities are considered. The enclosed additional guidance for safeguarding the participation of children and adolescents should be taken into account, and the accompanying consent/ assent forms should be used. As sometimes children can become distressed or may disclose abuse during the assessment, the Case Worker should be equipped to prevent and respond appropriately to distress and disclosure of abuse while conducting the assessment process.

**After the assessments have been completed, the CW should:**

1. Establish the date and time for the next visit with the household in the assessor's observations section at the end of the assessment tool. This visit should take place within the following weeks and should be scheduled appropriately to the identified risk. **Note:** *If during the assessment any **urgent or life-threatening needs are identified**, the Case Worker should be prepared to immediately provide a referral to the appropriate organization by filling a **Service Provision and Referral Form – OVCNIS 009** (see Step 5). Examples of urgent or life-threatening risks include all forms of abuse / violence against children or malnourishment.*
2. Prepare to review the household members' assessment results and goals with the CDO / Case Manager.
3. The date of assessment, the assessor's name, title, signature and contact should always be filled in on the HVAT/AVAT

**The PSWO/CDO/Case Manager should:**

1. Support the Case Worker in identifying the needs and strengths of the household members based on the assessment results. This conversation is critical because the **Household Vulnerability Prioritization Tool**, the **Household Vulnerability Assessment Tool** and **Adolescents Vulnerability Assessment Tool (AVAT)** for Adolescents Aged 12–17 years do not provide scores that correlate with specific services to which a household, child, or adolescent should be referred. This conversation will inform the development of the household's and/or child/adolescent's case plan as the baseline data.
2. Give attention to strengthening the capacity and skills of Para-Social Workers and providing the necessary support to ensure they can appropriately respond to children and adolescents who are distressed and/or show signs of or disclose abuse (including sexual abuse).
3. The Assessment Tool and baseline results will be used later for periodic monitoring of the progress of the household, child or adolescent out of vulnerability.



## **CM STEP 2 – ADDITIONAL GUIDANCE – COMMUNICATING WITH CHILDREN AND CAREGIVERS AND DISCUSSING SENSITIVE TOPICS**

### **COMMUNICATING WITH CHILDREN AND CAREGIVERS**

An integral part of the CM process is engaging both caregivers and children and ensuring that they feel they are part of and own the process. This engagement helps to build trust, mutual respect, and a desire to work together with the Case Worker. How the Case Worker communicates with children and caregivers is central for this to happen. In the context of OVC programming, sensitive topics such as HIV and child protection issues are discussed. How the Case Worker, PSWO or CDO communicates and interacts with children and caregivers is even more important when discussing these sensitive topics. Effective communication consists of asking the right questions to prompt the necessary information, while at the same time listening and interacting in a way that expresses respect and empathy and builds trust.

### **BUILDING TRUST THROUGH CONFIDENTIALITY, HONESTY, AND KEEPING COMMITMENTS**

It is very important for the Case Worker, PSWO or CDO to regularly mention to the caregivers and children that all information shared will remain private and confidential, unless harm to self or others is disclosed. Respecting the confidentiality of the client is central to building trust. It is also critical that the Case Worker, PSWO or CDO always tells the truth and communicates clearly what will happen. It is important for the Case Worker, PSWO or CDO to help the client talk through his/her concerns and in the process, work out options for overcoming them.

### **DEMONSTRATING RESPECT AND CARE AND LISTENING WITH EMPATHY**

By listening closely to the caregivers and the children, the Case Worker, PSWO or CDO is able to build trust and begin to support the client who has often experienced hardship. This trust and support will help the Case Worker, PSWO or CDO discuss difficult topics such as issues of violence and HIV.

### **NONVERBAL COMMUNICATION**

Nonverbal communication is also very important. In general, there are forms of nonverbal communication that are commonly understood to convey respect and empathy, while others convey lack of care, disapproval, or lack of attention. The Case Worker, PSWO or CDO should ensure his or her nonverbal communication demonstrates empathy, care, and respect. In addition, it is critical for the Case Worker, PSWO or CDO to observe and gather information from the children and caregivers' nonverbal communications. These can include eye contact, gestures, facial expressions, body positions, interpersonal distance, and unintelligible sounds made.

### **HOW TO COMMUNICATE WITH CHILDREN**

Communicating with children and adolescents needs to take into account their developmental stage. It is important for the Case Worker, PSWO or CDO to understand children and adolescents from their perspective. For example, it is helpful for the Case Worker, PSWO or CDO to sit down to be at the same level and height as the child and engage him/her in a friendly way to build rapport and trust.

Young children may find it easier to build rapport by drawing, playing games, or reading a book with the Case Worker, PSWO or CDO. For example, drawing or pointing to sad or happy faces or pictures might be easier for young children than communicating verbally.

This type of activity may also help when communicating with a child who has a learning or speech impairment. In these cases, the Case Worker, PSWO or CDO can also reach out to his/her supervisor and the IP to discuss if it might be helpful to get assistance from someone with specific expertise in working with children with disabilities.

When speaking with adolescents, the Case Worker, PSWO or CDO can start the conversation by discussing topics that interest them and asking what they like, such as their favourite food, school subject, or music, or what they want to be when they grow up. Some adolescents find it easier to communicate while they are walking together or when they are in a vehicle, as long as others are not around.

## DISCUSSING SENSITIVE TOPICS

In many instances, children are not always free to open up about what is really troubling them, in particular when it concerns sensitive topics such as child protection or HIV-related issues. However, they often can show and share what is troubling them through play and nonverbal communications. It is important for the Case Worker, PSWO or CDO to consider the child or adolescent's behaviour and overall nonverbal communication.

## CHILD PROTECTION ISSUES

Children and adolescents can at times not wish to share thoughts or feelings, or even say what has happened, for fear of negative consequences for themselves or others.

For example, an adolescent may feel that he/she was responsible, if he/she was abused when out socializing. In such cases, it is important for the Case Worker, PSWO or CDO to make it clear that he/she is not being judgmental and that it is okay for adolescents to do what they do.

Children may also be conscious of the consequences of 'getting other people into trouble.' It is very important for the Case Worker, PSWO or CDO to highlight that their conversation is private and confidential and that no information will be shared with others. In cases of abuse and in particular sexual abuse, children and adolescents might not feel comfortable talking to a Case Worker, PSWO or CDO who is of the same gender as the abuser. In this case, the Case Worker should notify his/her supervisor and together identify a Case Worker of the gender the child is most comfortable talking with.

The Case Worker, PSWO or CDO should keep in mind that traumatised children are often in shock and may not be able to engage. Sometimes this lack of engagement can be misunderstood as the child being unwilling to talk. It is also important for the child to not be re-traumatised by telling the story again. If the Case Worker sees the child getting very upset, the Case Worker should comfort him/her and redirect the discussion to another topic or stop the interview in a calm and supportive way.

***The Case Worker should report all cases of abuse as soon as possible to his/her supervisor, the IP social worker or Case Manager, the CDO, or the senior PSWO to ensure the child receives emergency services immediately.***

## HIV-RELATED ISSUES

When discussing topics related to HIV, it is very important for the Case Worker, PSWO or CDO to highlight to the caregiver and children that if they feel uncomfortable in any way answering any of the questions, they can say they do not want to answer

and the Case Worker, PSWO or CDO will stop. It is important to reiterate that all the answers will be private and confidential to reassure the caregiver and the children that none of this information will be shared.

With a child, the Case Worker, PSWO or CDO should use clear and developmentally appropriate explanations and discuss these topics with confidence. It is important for the Case Worker, PSWO or CDO to talk with the child and not to let the child tell his/her story. The Case Worker, PSWO or CDO should let the child ask questions and should respond as clearly as possible. The Case Worker should discuss with the child what information the child feels comfortable sharing and with whom.

With adolescents, the Case Worker, PSWO or CDO should provide full information to ensure that the adolescent can make his/her own choices. The Case Worker, PSWO or CDO should enable adolescents to take responsibility for their health and well-being.

In all cases, the Case Worker, PSWO or CDO should reassure the child, adolescent, and/or caregiver that he or she is there to provide them with support.

## MANAGING HOSTILITY OR RESISTANCE

When discussing difficult topics, the Case Worker, PSWO or CDO might encounter hostility or resistance. In these instances, he/she should stay calm and neutral. People in a crisis can become emotional, so maintaining calmness and stability is very important. This will, in most instances, prevent the situation from escalating and can provide an opportunity for the caregiver, child, or adolescent to express his/her emotions.

People can resist for many reasons: a caregiver who seems very depressed and does not want to set any goals may need support with his/her depression first. A mother who is hostile may be afraid that her children may be taken away from her.

The Case Worker, PSWO or CDO should remind the caregiver, child, or adolescent that they are meeting so he/she can be helped and supported with his/her issues. The Case Worker should listen carefully to what is being said, both in terms of content and emotions, and also observe nonverbal communication behaviours. He/she should respond in a respectful, empathetic manner.

If the client continues to be hostile, angry, or upset, the Case Worker should stop the conversation in a calm but firm way, leave the household, and contact the supervisor and possibly the PSWO or CDO or the police as soon as possible.



## **GUIDANCE<sup>1</sup> FOR SAFEGUARDING THE PARTICIPATION OF CHILDREN AND CAREGIVERS IN CASE MANAGEMENT AND IN MONITORING AND EVALUATION**

### **WHAT DOES THE PARTICIPATION OF CHILDREN AND CAREGIVERS MEAN?**

Participation is about children and caregivers having the opportunity to express their views and opinions, influence decision-making, and achieve change. It is about recognizing children and caregivers as equal partners in decisions that affect their protection and care, and as important actors within the child and family-focused system. It is also about recognizing that children have the right to express (or not express) their views at any particular time.

Article 12 of the United Nations Convention on the Rights of the Child (UNCRC) explicitly states that children of all ages and abilities, including the most marginalized, should have a say in any matter concerning them, and that their participation should be informed and voluntary. The CRC Committee General Comment<sup>5</sup> on child participation emphasises that children have the right to actively and intentionally participate and express their views and opinions in issues that affect their lives according to their age and evolving capacities.

Children are citizens, as well as family and community members, from the moment of their birth, yet they are often treated as though they are less important than adults, with opinions and views of lesser value and with a lower capacity to participate. Adults have more power than children, physically, in social life, and economically. The way adults choose to exercise or share this power can enable or prevent children from fulfilling their potential as active citizens and family and community members.

### **WHY IS CHILDREN AND CAREGIVERS' PARTICIPATION IMPORTANT?**

Children's participation should be an ongoing process rather than an event or a one-off activity. When it is done properly, children develop new skills, increase their confidence and knowledge, and see that their views are valued and respected. They are also more likely to be cooperative when they have been able to actively engage with the more difficult decisions relating to their own lives. Such engagement leads to healthier outcomes for the child in the long term.

Seeking the participation of children and caregivers is also important from a resilience-strengthening perspective. Children and caregivers who are more resilient tend to have higher self-esteem, self-worth, and confidence; a sense of being able to have some control over their lives; and the ability to make a difference (locus of control). Thus, they are better able to make good choices for themselves and their family members. Case Workers, PSWO or CDO can support and strengthen these qualities in children and caregivers by facilitating their full participation, focusing on their strengths and resources (as opposed to their needs and deficits), and acting with respect, care, and empathy. Caregivers and children are more likely to be open to new ideas and to listen during difficult conversations if they feel like they are partners and have a vested interest in the conversations and decisions. Actions, such as referral to services, are more likely to be aligned to needs and more likely to be followed through with a caregiver or child who feels that he/she is a partner in the process.

### **FACILITATING MEANINGFUL PARTICIPATION OF CHILDREN AND CAREGIVERS**

Agencies and Case Workers, PSWO or CDO are responsible for not only communicating with children and caregivers about their right to participate (including the right not to answer questions that make them uncomfortable) but also intentionally engaging and supporting them to claim this right throughout the CM process. Children's and caregivers' participation helps to prevent a Case Worker from coming to a decision that may be in their best interests but that is against their wishes (e.g., removing the child from an abusive home). Social workers should explain such decisions to the child and caregiver with care and empathy and should ensure that, if a decision is against a child's wishes, the reasons are explained and solutions found to address the child's fears or concerns.

It is important to remember that a child's ability to make decisions is related to his or her age, maturity, and evolving capacities. Even very young children are able to participate in decisions, although this may take more time and skills from the Case Worker to be able

**The Senior PSWO/CDO/Case Worker/Case Manager should use his/her professional judgment to decide if it is in his/her clients' best interests to attend a meeting.**

**Participating in a decision-making process such as a case conference can be empowering for the client if the attendees are likely to be respectful, if there are no immediate risks to the client (e.g., being confronted by an abuser or family member), and if there is likely to be harmony in the group.**

<sup>5</sup> CRC Committee. 2009. General Comment on the Right of the Child to be Heard. Geneva: United Nations. <http://www2.ohchr.org/english/bodies/crc/docs/AdvanceVersions/CRC-C-GC-12.pdf> (accessed Sept. 14, 2018).



to support the child to voice their views. Children have the right to receive information in an appropriate way and in appropriate language so they understand what is happening throughout the CM process. They have the right to ask questions when they do not understand and should be encouraged to do so.

In contexts where children's and/or caregivers' status is weak (e.g., due to gender, ethnicity, or disability) or where it is not culturally or socially acceptable for them to participate, children and caregivers may be less at ease or feel less confident in participating and in making decisions. This process may be very new to them. Case workers should recognize the context in which participation occurs and should seek ways to help the child and caregiver feel at ease and able to engage. For example, a caregiver and child may feel comfortable talking one-on-one with a Case Worker but may have more difficulties participating in a large case conference or speaking out in court. Case Workers, PSWO or CDO have a role to play in encouraging children and caregivers to voice their concerns and in reassuring them about their ability to make decisions, which builds a trustful relationship between Case Worker and client. Particularly in contexts where it may be unsafe for children and/or caregivers to speak out publicly, Case Workers, PSWO or CDO have a responsibility to create a safe and confidential space for the child and/or caregiver to participate in his/her own case, even quietly and privately (e.g., in the case of court proceedings, this might involve a one-on-one meeting with a Case Worker as a mentor, followed by recording of the case, video links, etc.). Upholding confidentiality and

considering safety in the development of case plans are essential to ensuring children and caregivers are not placed at risk.

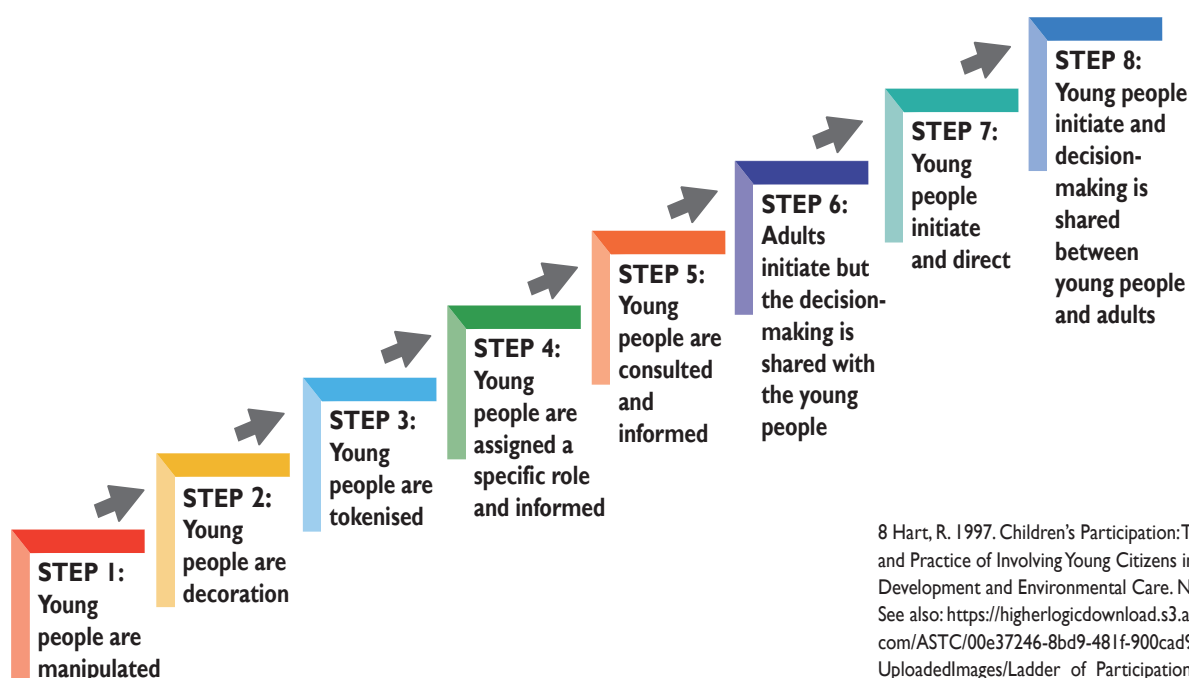
Social workers should make sure that children know what is about to happen, who is responsible for making it happen, and how long it should take. Children should always know whom they can contact and how they can do this, including when children do not have access to phones. A Case Worker may need to identify and work with a trusted adult that the child is comfortable with.

## LEVELS OF PARTICIPATION OR INVOLVEMENT OF CHILDREN AND CAREGIVERS

Levels or degrees of child participation range from no participation at all or even manipulation of the child, to children initiating and fully sharing in the decision-making with adults, as reflected on the "Ladder of Young People's Participation" described by the sociologist Roger Hart.

In the context of integrated child welfare services, the involvement of children and caregivers who are the clients of such services can be broadly categorized into three levels:

- **Level 1)** Children and caregivers are informed and/or consulted: Children are well-informed about what the Case Worker, PSWO or CDO or Case Manager is doing and why. The Case Worker might also consult them to check that he/she is working in the right way. Children's involvement is valuable but remains quite passive.



8 Hart, R. 1997. Children's Participation: The Theory and Practice of Involving Young Citizens in Community Development and Environmental Care. New York: UNICEF. See also: [https://higherlogicdownload.s3.amazonaws.com/ASTC/00e37246-8bd9-481f-900cad9d6b6b3393/UploadedImages/Ladder\\_of\\_Participation\\_1.pdf](https://higherlogicdownload.s3.amazonaws.com/ASTC/00e37246-8bd9-481f-900cad9d6b6b3393/UploadedImages/Ladder_of_Participation_1.pdf)

- **Level 2)** Children and caregivers collaborate and/or share decision-making with social workers or Case Managers: Children and caregivers collaborate with the social worker and share decision-making with them. This approach can be social worker-initiated or client-initiated, but the social worker and the client (child and/or caregiver) respect one another and are equal stakeholders in the intervention.
- **Level 3)** Children and caregivers lead the intervention: Children and caregivers take the lead and initiate their own intervention. They may seek support or guidance from the social worker, but this is optional.

It is not always possible to categorise an activity with children on any one of these three levels. In fact, a project or activity may operate at any one of these levels at different times. However, there are certain characteristics of participatory work with children that will help determine their level of involvement:



LOW-LEVEL INVOLVEMENT	MEDIUM/HIGH-LEVEL INVOLVEMENT
<ul style="list-style-type: none"> <li>• Children and caregivers are passive 'beneficiaries' or 'patients'</li> <li>• Case Workers and service providers take the lead</li> <li>• Case Workers and service providers design and set the parameters of the activity</li> <li>• Children and caregivers are invited to take part in something designed by Case Workers and service providers</li> <li>• Children and caregivers are informed and consulted</li> <li>• These are time-limited or one-off activities</li> <li>• Case Workers and service providers have most of the power</li> <li>• Case Workers and service providers are prepared to listen to and incorporate children's and caregivers' views</li> </ul>	<ul style="list-style-type: none"> <li>• Children and caregivers are active protagonists</li> <li>• Children and caregivers collaborate with Case Workers and service providers</li> <li>• Case Workers/service providers and children/caregivers share decision-making</li> <li>• Case Workers/service providers and children/caregivers respect one another as equal stakeholders</li> <li>• Children and caregivers are involved in designing activities</li> <li>• Children and caregivers facilitate or run interventions</li> <li>• Children's and caregivers' participation leads to change</li> <li>• Children and caregivers gain new skills</li> <li>• Sometimes (but not always) these are longer-term activities</li> <li>• Children and caregivers take the lead and ask for support from Case Workers and service providers when necessary</li> </ul>

## HOW TO ENSURE THE PARTICIPATION OF CHILDREN AND CAREGIVERS

The following table shows how to involve children and caregivers at the planning, implementation, monitoring, and evaluation stages of an intervention. It also illustrates that their level of involvement may vary according to the activity or stage of intervention. They may be more involved at certain times than others; there may be times when a Case Worker needs to make a decision with less consultation.

	KEPT INFORMED ABOUT ACTIVITIES	CONSULTATION	PROVIDE INPUTS	COLLABORATION	CHILD AND CAREGIVER-LED
<b>Planning</b>	Children and caregivers are informed about planning the intervention	Children's and caregivers' views are incorporated into intervention planning through interviews and opportunities to clearly explain what is going to happen in verbal, written, or pictorial form, for example	Children and caregivers help collect information relating to potential strengths-based interventions that they would like to see happen	Children and caregivers have significant influence on decisions at the planning stage, for example, in determining when, where, and how the actions in the case plan should take place	Children and caregivers have control and influence over the intervention at the planning stage
<b>Implementation</b>	Children and caregivers are provided with information about what is going to happen, when, and with whom	Children and caregivers are consulted and their views are incorporated as activities or interventions are initiated	Children and caregivers take part in implementing the action in the case plan	Children and caregivers have a partnership role in the intervention, including decision-making responsibility	Children and caregivers implement the actions in their case plan themselves
<b>Monitoring</b>	Children and caregivers are provided with information about how the intervention is working	Children and caregivers are asked for their opinions on how the intervention is working	Children and caregivers help collect information on the progress of the intervention	Children and caregivers have influence over how monitoring is done, e.g., what questions are asked, what data are collected, how it is presented, how findings are analysed	Children and caregivers are in control of the monitoring process, for example by recording every time they have taken an agreed-upon action in the case plan
<b>Evaluation</b>	Children and caregivers are given information about the intervention and its effects and impact	Children and caregivers are asked for their views on the effects and impact of the intervention on their lives	Children and caregivers help collect information about the effectiveness of the intervention	Children and caregivers are involved in the analysis and conclusions about the intervention's effectiveness	Children and caregivers are in control of evaluation

At any one time, children and caregivers may have different levels of involvement. This may depend on a number of factors, including their capacity, resources, and time. How an activity is facilitated and the extent to which barriers interfere with participation can also seriously impact involvement, i.e., often resources and time can get in the way of really enabling children or caregivers to participate. It is not necessarily better to operate at a higher level of involvement, but it is useful to analyse how much children and caregivers are involved and engaged. This will help the Case Worker to plan and evaluate, ensuring that both the children/caregivers and the Case Worker are clear about what they each expect of the other.

### **PROTECTION CONSIDERATIONS WHEN SEEKING THE PARTICIPATION OF CHILDREN**

As a general principle, permission to proceed with CM (and other case actions) or to collect information (including for M&E purposes) should be sought from both the child and the parent or caregiver, unless it is deemed inappropriate to involve the child's parent or caregiver, for example when the child's parent or caregiver is being considered an alleged perpetrator in a child protection concern.

Explaining the proposed services, including the need to collect, store, and possibly share the child's and/or caregivers' information, and obtaining permission to proceed does not need to be complicated. However, Case Workers are required to know how to obtain permission based on the local laws, the child's age and maturity level, and the presence of non-offending parent or caregiver.

Permission to proceed with CM, other care and treatment actions (e.g., referrals), and information collection is sought by obtaining "informed consent" from caregivers or adolescents and/or "informed assent" from younger children. Informed consent and informed assent are similar, but not exactly the same.

**"Informed consent"** is the voluntary agreement of an individual who has the legal capacity to give permission. To provide "informed consent," the individual must have the capacity and maturity to know about and understand the services being offered or information being requested and how this information will be used. The individual must also be legally able to give their consent. Parents or guardians are typically responsible for giving legal consent for their child to receive services or take part in interviews or audio and/or visual recordings. In some settings, older adolescents are also legally able to provide consent in lieu of, or in addition to, their parent or caregiver.

**"Informed assent"** is the expressed willingness to participate in services or provide information. For

younger children who are by definition too young to give informed consent, but who are old enough to understand and agree to participate in services or provide information, the child's informed assent is sought. Informed assent must be clearly documented with the date, place, and nature of the assent, by the person to whom the child has provided informed assent.

Consent thus involves the child and/or his/her caregiver having a clear understanding of the purpose of the CM and/or information collection. An informed written or verbal assent/consent from the child and/or his/her guardian should be documented before the information (in whatever form) is collected.

Children and caregivers should be given the opportunity to highlight any information that they do not want disclosed to any particular person. For example, they may not want their family to be told personal details about them that they would rather communicate face-to-face or not at all.

Case Workers should always offer children and caregivers the opportunity to ask questions or share concerns during this discussion. In situations where children and/or caregivers are hesitant to proceed, the Case Worker should ask additional questions to determine the reason for their hesitation. Perhaps the child and/or caregiver is afraid of losing the his/her confidentiality because of a mandatory reporting law. Case Workers should take the time to discuss the child's and/or caregiver's fears and concerns before proceeding with CM and provide clear and accurate answers to address them specifically. If the child and/or caregiver decides not to participate, then that is their right, which should be fully respected. Examples of informed consent forms for use with children and caregivers are provided on the next pages.



**SAMPLE INFORMED ASSENT FORM FOR CHILDREN / YOUNG PEOPLE**  
**(aged 08 - 17 years)**

**NAME OF THE CHILD:** \_\_\_\_\_

Children aged 8 years and older must assent to the interview, and their assent must be accompanied by parent/guardian consent (wherever possible). This form should be read to the child in the language he/she best understands and should be completed based on his/her answers. It should be clearly explained to the child, in a manner appropriate to his/her capacity, that he/she can choose any or none of the options listed.

**PLEASE TICK THE BOXES YOU AGREE WITH.**

I understand the purpose of this discussion and of any photos that might be taken. Yes ☐ No ☐

I understand that any information I provide will be treated with confidentiality and respect and will only be used for the purpose of case management. Any information I provide will be kept in a locked file that can only be accessed by the [organization name] persons assigned to conduct this review study.

I am happy to participate in this discussion/interview and to share information for the purpose of case management only. Yes ☐ No ☐

I am happy to have my photo taken with other children or staff in a group and understand that my real name and personal details will not be revealed in a caption to this photo, in any accompanying story or in any other report, materials, media, or website. Yes ☐ No ☐

I understand that at any point, I have the right to change my mind about sharing my information with [organization name] or anyone else working with [organization name].  
Yes ☐ No ☐

Signature/Thumbprint of child: \_\_\_\_\_

Parent or guardian name and signature, if obtainable:

Name: \_\_\_\_\_ Signed: \_\_\_\_\_

[Government Department/ Organization name]:

Name of Staff \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Official Stamp: \_\_\_\_\_

**SAMPLE CONSENT FORM FOR PARENT/CAREGIVERS OF CHILDREN WHO ARE YOUNGER THAN THE AGE OF ASSENT FOR INTERVIEW AND USE OF PHOTOGRAPHS (<8 years)**

**PLEASE TICK THE BOXES YOU AGREE WITH.**

I understand the purpose of this discussion/interview and hereby agree that any information I provide will be used for the purpose of [organization name] programme review, as has been explained to me.

Yes ☐

No ☐

I give permission to [organization name] to take photographs of myself and my child and to use these for the purpose of [organization name] information collection. I understand that our real names and personal details will never be revealed in a caption to these photos, in any accompanying story or in any other reports, materials, media, or website.

Yes ☐

No ☐

**AGREED TO BY:**

\_\_\_\_\_  
Signature of parent/caregiver

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature/thumb print of child

\_\_\_\_\_  
Print name names of children represented by parents/caregiver.

\_\_\_\_\_  
Date



# STEP 3



## ENROLMENT

3



## CM STEP 3 – STANDARD OPERATING PROCEDURE FOR ENROLMENT

**WHAT:** Enrolment is the process of registering children and households that are eligible for and want to participate in the OVC programme.

### TOOLS:



- Tool 1: Household Enrolment Form (OVCMIS FORM 008)
- Tool 2: Childcare and Protection Case Record Form (OVCMIS FORM 004A)
- Tool 3: Integrated OVC Service Register (OVCMIS FORM 004B)
- Additional guidance – Communicating with Children and Caregivers and Discussing Sensitive Topics (see Step 2)
- Additional guidance – Explaining Case Management and Case Plan Achievement to Families
- Uganda Case Plan Achievement Benchmarks/Indicators for OVC Programming (see Step 4)
- Additional guidance – Data Protection Protocols (see Step 1)

### WHO FACILITATES:

Case Workers facilitate with the support of a Case Manager in collaboration with the sub-county CDO and / or the PSWO.

### WHO PARTICIPATES:

All members of a household participate, and a community leader, if possible, acts as a witness.

### HOW:

#### The Case Worker should:

1. Visit, with the community leader, the households the Case Manager has assigned to him/her. During this first visit, the Case Worker should:
  - Introduce him/herself to all members of the household, including the children  
(Note: See Step 2: Additional guidance – Communicating with Children and Caregivers and Discussing Sensitive Topics).
  - Introduce the OVC programme.
  - Explain what it means to participate in CM and work towards case plan achievement  
(Note: See Additional guidance – Explaining Case Management and Case Plan Achievement to Families).
  - Ask the members of the household if they want to participate in the programme.
  - Build rapport<sup>6</sup> (Note: See CM Step 1 “Ways to Build Rapport” text box).
2. Complete a Household Enrolment Form for the household if the children and their caregivers want to participate in the programme<sup>7</sup>. Where possible, a community leader should witness the members of the household agreeing to participate in the programme.
3. For referred or walk-in cases of caregivers, unaccompanied young children and adolescents, PSWO/ CDO/Case Manager/ Case Worker should capture the initial case details and action taken in the Childcare and Protection Case Record Form (OVCMIS Form 004A). These include the case reference number, date, name of the child/adolescent, age, sex, Village, parish/sub-county of residence, name of caregiver/parent, details of rights violated and the perpetrator.

#### The Case Worker/Case Manager/PSWO/CDO should:

1. Document the enrolled child(ren)’s and household’s information in relevant OVC registers according to governmental or organizational policies.
2. Establish a family case file that will be stored in a secure location. (Note: See Step 1: Additional guidance – Data Protection Protocols).
3. Assign the members of the household unique identifiers according to governmental or organizational protocols.

<sup>6</sup> Hepworth, D. H., R. H. Rooney, G. D. Rooney, K. Strom-Gottfried and J. Larsen. 2010. Direct Social Work Practice: Theory and Skills. Belmont, CA: Brooks/Cole Cengage Learning.

<sup>7</sup> If the children and caregivers do not want to participate in the programme, the case worker should report this to the case manager.



### CM STEP 3 – STANDARD OPERATING PROCEDURE FOR USING THE INTEGRATED OVC SERVICE REGISTER



- Tool 1: Household enrollment Form (OVCMIS FORM 008)
- Tool 2: Integrated OVC Service Register (OVCMIS FORM 004B)

The objective for the using the integrated OVC service register in child programming is to register all OVC and document services the children and their households received during the specific reporting period. A single copy of the register will be in use to promote confidentiality and it shall be kept at the service provision facility offices. The head of the Service Provider Organization/Institution will be responsible to ensure safe custody of the register away from unauthorized persons.

**The procedure for the use of the** integrated OVC service register includes the following:

- i. Write the name of OVC service provider, Institution/ Organization, district of operation, date the register is opened, and date the register is closed on the front cover of the Integrated OVC Register.
- ii. Before entering OVC data in the OVC Integrated Register make sure that information is captured in activity reports, beneficiary lists, enrolment cards and other primary records.
- iii. Indicate the date when the child was registered and the period when s/he started receiving services.
- iv. Much as some children do not have national identification numbers (IDs), service providers are required to issue unique IDs for the children they offer a service. Thus, ensure that the OVC unique identification number captured in the Integrated OVC Register is similar to the OVC number which was captured in the **HOUSEHOLD ENROLMENT FORM (OVCMIS 008)** during the enrolment exercise.
- v. In case the child is under the care of another Caregiver different from the Parent /Guardian recorded in the **HOUSEHOLD ENROLMENT FORM (OVCMIS 008)**, record the names of the current Caregiver in this Register.
- vi. Because the information recorded in this register is sensitive and confidential it's important that this Register is kept in a secure place and strictly accessed by authorized persons only.
- vii. Use data captured in the activity reports, beneficiary distribution forms and other related OVC documents to identify services provided to the OVC during the period under review and then use this data to complete the services provided sections.

### DESCRIPTION OF COLUMNS

Fill in all relevant columns during registration of the OVC into the OVC program (columns 1-10), whenever the OVC is provided services fill the services provided column under the respective services and quarter while for the OVC exiting the OVC program fill the exit column under the respective exit year. These columns should be completed as described in the column descriptions below;

#### (1) DATE OF REGISTRATION:

Enter the date when the child is enrolled into OVC programme (Day/Month/Year) as indicated in the Child Enrolment and Monitoring Card.

#### (2) OVC UNIQUE IDENTITY (ID) NUMBER/HOUSEHOLD NUMBER/NIN:

In the upper row enter the **NIN** or unique identification number of the OVC, the MGLSD recommends that the unique OVC ID should specify 4 digit child number, two digits for the month of registration and four digits for year of registration for example 0000/MM/YYYY but if the organization has its own unique way of allocating OVC ID numbers, then they should use theirs.

In the lower row enter the Household Number/ID as entered in OVCMIS FORM 008: HOUSEHOLD ENROLMENT FORM

### (3) NAME OF THE CHILD:

Enter the surname and the first name of the child in full as indicated on the HOUSEHOLD ENROLMENT FORM (OVCMIS 008).

### (4) CHILD'S AGE, CHILD'S DATE OF BIRTH AND CHILD'S SEX (M\F):

In the upper row, enter the child's age in complete years if the child is 1 year or greater than 1 year and, write the child's age in month if the child is less than 1 year.

In the Middle row enter the date of birth of the child (Date/Month/Year) as indicated on the birth registration certificate, immunization card or as reported by caregiver

In the last row enter the sex of the child as M for Male and F for Female.

### (5) CAREGIVER:

Enter the caregiver's surname and first name in full, his/her age in complete years and the code for the option that best describes his/her relationship with the child for example Father, Mother, Uncle, Aunt, Grandparent, Brother or Sister.

### (6) RESIDENCE OF OVC:

Enter the District, Sub-county, Parish/Ward and Village/LC I Cell/Zone where the child currently stays.

### (7) VULNERABILITY/REFERRAL STATUS:

In this column enter the code representing the type of vulnerability in the upper row as indicated in the Child Enrolment and Monitoring Card ((1) Orphan (2) Disabled (3) Abused (4) In contact /conflict with law (5) HIV+ (6) In child headed family (7) Living on Street (8) Out of School (9) Poverty stricken (10) Under elderly/disabled care giver (11) HIV Exposed Infants (12) Pregnant adolescents (13) Child of HIV positive care giver (14) Other),

In the second row enter the status of child's vulnerability level as critically, moderately or slightly vulnerable as recorded during enrollment into the OVC program.

In the third/last row enter the name of the Organisation where the OVC was referred from in case the OVC was referred from another OVC Service Provider Organisation to this Organisation. Data on the referral status can be obtained from the OVC Service and Referral Form or any other related referral document.

### (8) CHILD'S HIV STATUS:

Enter the code for the child's HIV status, "1" if child is HIV Positive, "2" if the child is HIV Negative and "3" if the child's status is not known.

### (9) SERVICE(S) REQUIRED:

In this column enter the respective unique PA number representing the services required by the child  
**I-Economic Stability and Security** (Economic

strengthening), **II-Survival and Health** (Food and Nutrition, Health/Water/Shelter, HTS Status, HIV Care Status and HIV Prevention), **III-Education and Development** (Education support), and **IV-Care and Protection** (Psychosocial Support -PSS, Legal and child protection, Violence Against Children-VAC, Gender Based Violence -GBV, Disability), these should be the services required to positively change the vulnerability status of the child.

## SERVICES PROVIDED SECTION

This format requires that a service provider indicates the services provided to a child until exit. Please indicate the current year in the upper row of the page in the register where there is YEAR, this should also be done in the follow-on years on the next 2 pages of the register. Under column 1, indicate the OVC NIN or Unique ID, the current age of the OVC, the house Hold number/ID and the current vulnerability level of the OVC.

Document at the end of each quarter, the services provided to each OVC using the codes provided at the bottom of this register (the information on services provided to OVC within the respective quarter can be obtained from the House Hold Home visit form and/or other OVC related source documents used for capturing services provided to the OVC for example OVC activity reports, distribution lists etc.)

### NOTE:

1. For OVC referred to other Service Providers for specific services, please use the referral codes under the respective PAs and also indicate the Organization where the OVC has been referred to.
2. For the OVC exiting a program within any quarter of current year, exit details are captured in the last column "EXIT" under the respective year. Details captured on exit include: 1-Date of exit, 2-Reason of exit (use the codes for reasons for exit at the bottom of the register) and services provided on exit.
3. For services provided during exit, use the respective unique PA number representing the services provided to the child during exit e.g. I-Economic Stability and Security, II-Survival and Health, III-Education and Development, and IV-Care and Protection, these should be the services required to positively change the vulnerability status of the child.



# STEP 4

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## CASE PLAN DEVELOPMENT AND UPDATING

# 4





## CM STEP 4 – STANDARD OPERATING PROCEDURE FOR CASE PLAN DEVELOPMENT AND UPDATING

### WHAT:

Developing a case plan is the process of creating a written plan that outlines how to improve the well-being and safety of a child and increase the resilience of the child, adolescent and caregiver or household. Case plans include actions that need to be taken to achieve both the goals set by the child and household and those of the OVC programme. Each member of the household, including all children and adolescents, should have a case plan that is summarized within a Household case plan at the family level.

### TOOLS:



- Tool 1: Household Vulnerability Assessment Tool (HVAT) (OVCMIS FORM 007A)
- Tool 2: Adolescent Vulnerability Assessment Tool (AVAT) for Adolescents Aged 12–17years (OVCMIS FORM 007B)
- Tool 1: Case Planning with Caregivers (18+years), Children (8–11 years, Adolescents Aged 12–17years) (OVCMIS FORM 012A)
- Tool 2: Summary of Key Priority Actions to Share with the Household/Adolescents
- SOP on Uganda Case Plan Achievement Benchmarks/Indicators for OVC Programming

### WHO FACILITATES:

Facilitators include the Case Worker/Case Manager; or the PSWO in the case of children in contact or in conflict with the law, VAC, GBV, with disability, unaccompanied children; or the Warden of the child care institution in the case of children in institutions, in collaboration with the IP Case Worker or in coordination with the PSWO / CDO.

### WHO PARTICIPATES:

The **vulnerable HH** or unaccompanied child for whom the case plan is being developed and all members of the household participate.

### HOW:

#### The Case Worker should:

1. Jointly review the results of the Household and Adolescent Vulnerability Assessment Tools with the Case Manager before developing the case plan.
2. After reviewing the results, develop case plans for the household, Children and adolescents. A single template for case planning is provided for case planning with Caregivers, Young Children aged 8–11 years and Adolescents Aged 12–17 years. Select the appropriate category to participate in the case plan development. **Note: The case plan should be partially filled out (i.e., biodata, etc.) by the Case Worker/CDO prior to the visit but the rest of the information, especially goals and actions, should be filled out together with the members of the household or unaccompanied child.**
3. Begin the development of the case plan by working with the caregiver, young children, or adolescent to identify how they would like to see themselves and their household grow and improve over the next year. The Uganda Case Plan Achievement Benchmarks/Indicators for OVC Programming should be used as a guide to set goals for the caregiver, the child or adolescent to become more resilient over the next year. These goals should reflect the improvement the caregiver and child/adolescent wish to achieve. Note: Goals should be achievable within one year because the OVC programme will not be able to provide services indefinitely. Please use the information gathered from the HVAT, AVAT and benchmark indicators to help complete the Case Plan. The same case planning template can be used by Approved Homes for children being reintegrated into families or independent living.



4. List all the coded services at the bottom of the case planning template to be provided or referred for the caregiver, child or adolescents by the organization / institution.
5. List all services to be referred to other organizations or government departments, to be consented to by the caregiver or assented to by the adolescent.

#### STEP 4, CASE PLAN DEVELOPMENT AND UPDATING

6. After the case planning tools have been completed, complete the Summary of Key Priority Actions to Share with the Household and share it with the head of the household (or the Summary of Key Priority Actions to Share with the Adolescent if the Case Worker worked with an adolescent). Note: It is important that the Case Worker share the information, including the agreed-upon goals and the steps that need to be taken to reach those goals, with members of the household, as appropriate. Their active engagement in the process is key to helping them reach their goals. Do not include any confidential information that the caregiver, child or Adolescent does not want to share with others.
7. Share with the members of the household the Uganda Case Plan Achievement Benchmarks/Indicators for OVC Programming and ensure that they fully understand the goal of the OVC programme.
8. Establish the date and time for the next visit. Regular quarterly visits are a requirement. However the frequency of the visits depends on the severity of the case or magnitude of support required.

#### The Case Worker/Case Manager, PSWO, or child care institution Warden should:

1. Review the case plan with the Case Worker to ensure that all critical and related actions, service provision, and/or referrals are included in the case plan according to the needs of the household.
2. Support the Case Worker in addressing any identified emergency needs as soon as possible.
3. Store the case plan within the secure and confidential family case file. Depending on the project resources and if necessary, enter data electronically.

#### UPDATING CASE PLANS

The case plan should be used to guide the actions of the PSWO/CDO/Case Worker/Case Manager, and members of the OVC household. A useful way to think about a case plan is as a “road map” that helps the Case Worker and household know where they have come from and where they want to go, including who is responsible for doing what, when, and how so that the household can reach the final destination (i.e., case plan achievement).

The Case Worker, with support and oversight from the Case Manager, PSWO/CDO should use the case plan for ongoing monitoring visits. **Depending on the severity of the case, these visits could vary from once a week for very severe and complex cases to once a month or once a quarter for other types of cases.** At each visit, the Case Worker should identify completed actions (with a tick) and other necessary actions and should also document the reasons why some actions were changed or not completed. Any necessary support required to implement changes or incomplete actions should be agreed upon with the caregiver, child or adolescent.

The PEPFAR Site Improvement Monitoring System (SIMS) for CM recommends that a case plan be updated at least once every three months. It reads: Question 3 of SIMS for CM: 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)?

All copies of the case plan should be stored in the case file in chronological order, with the most recent case plan on top. As per good practice, case files, given the confidential information included within, should be stored in a safe and locked location (e.g., a storage or filing cabinet).

For more useful information on case planning, implementation of the case plan, and ongoing monitoring, please see: Guidance for PEPFAR Orphans and Vulnerable Children (OVC) Implementing Partners. Good practices in Case Management: How your OVC programme can be ready for a site improvement monitoring system (SIMS) assessment available at: [http://ovcsupport.org/wp-content/uploads/2017/09/17OS388-SIMS-case-management\\_FINAL\\_ONLINE.pdf](http://ovcsupport.org/wp-content/uploads/2017/09/17OS388-SIMS-case-management_FINAL_ONLINE.pdf).



## CM STEP 4 – ADDITIONAL GUIDANCE – EXPLAINING CASE MANAGEMENT AND CASE PLAN ACHIEVEMENT TO FAMILIES

OVC programmes use a CM approach that supports and engages OVC and their families. The following are suggestions for how to explain CM and how it works to children and caregivers.

**CM can be understood as a process that includes identifying, assessing, planning, and monitoring using specific tools and processes.** We, as members of the social service workforce, want caregivers and children to feel that they are a part of this process, so we make a concerted effort to engage them in ways that are based on trust, mutual respect, and a desire to work together. Many of the tools and approaches we use facilitate engagement of the caregivers and children. **We do not want to do this for them but with them.**

**We believe in the inherent strengths and resilience of caregivers and children.** CM focuses on strengths as well as identifies problems or needs. It is important, as a Case Worker or implementing partner, to always find something positive or something good that the child or caregiver is able to do or a resource they have. **Identifying those positive things helps to motivate them and builds their own confidence and ability to work towards a safer, healthier, and more stable environment.**

Case plan achievement is an approach to CM. **In simple terms, case plan achievement means that the household members (caregiver and children) or unaccompanied children have met the goals that they have set for themselves and that the programme has for them.** This is a big achievement and is the overall goal of CM. We want OVC programmes to contribute to households being stronger, being better able to care and support the children, and being able to address any health issues they face. Being in a better place than when they were enrolled in the OVC programme is considered an enormous success and should be celebrated.

**We use the Uganda Case Plan Achievement Benchmarks/Indicators for OVC Programming and the Ongoing Monitoring Tool not to judge the households but to help us track the goals of the OVC programme and to give some concrete examples of goals that the household can work towards.** These are outcomes or results that enable the household and the OVC programme to know that the household has achieved something and in what areas the OVC programme and the Case Worker can help them improve.

**Another way that we plan and monitor how the household is progressing in reaching those goals and completing actions is through a case plan.** The best way to understand a case plan is as a road map. The case plan helps the Case Worker and household know where they have come from and where they want to go, including who is responsible for doing what, when, and how so that the household can reach the final destination.

The best way to understand a case plan is as a “road map” that helps the Case Worker and household know where they have come from and where they want to go, including who is responsible for doing what, when, and how so that the household can reach the final destination.

### DEFINING VIOLENCE AGAINST CHILDREN

According to WHO, violence is “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation.” Violence thus includes more than acts leading to physical harm. Its consequences are far wider than deaths and injuries, and can include communicable and non-communicable disease, psychological harm, risky behaviours, educational and occupational underachievement and involvement in crime.

## TYPES OF VIOLENCE AGAINST CHILDREN

Most violence against children involves at least one of six main types of interpersonal violence that tend to occur at different stages in a child's development:

- **Maltreatment** (including violent punishment) involves physical, sexual and psychological/emotional violence; and neglect of infants, children and adolescents by parents, caregivers and other authority figures, most often in the home but also in settings such as schools and orphanages.
- **Bullying** (including cyber-bullying) is unwanted aggressive behaviour by another child or group of children who are neither siblings nor in a romantic relationship with the victim. It involves repeated physical, psychological or social harm, and often takes place in schools and other settings where children gather, and online.
- **Youth violence** is concentrated among those aged 10–29 years, occurs most often in community settings between acquaintances and strangers, includes physical assault with weapons (such as guns and knives) or without weapons, and may involve gang violence.
- **Intimate partner violence** (or domestic violence) involves violence by an intimate partner or ex-partner. Although males can also be victims, intimate partner violence disproportionately affects females. It commonly occurs against girls within child and early/ forced marriages. Among romantically involved but unmarried adolescents it is sometimes called “dating violence”.
- **Sexual violence** includes non-consensual completed or attempted sexual contact; non-consensual acts of a sexual nature not involving contact (such as voyeurism or sexual harassment); acts of sexual trafficking committed against someone who is unable to consent or refuse; and online exploitation.
- **Emotional or psychological violence** and witnessing violence includes restricting a child's movements, denigration, ridicule, threats and intimidation, discrimination, rejection and other non-physical forms of hostile treatment. Witnessing violence can involve forcing a child to observe an act of violence, or the incidental witnessing of violence between two or more other persons.

When directed against girls or boys because of their biological sex or gender identity, any of these types of violence can also constitute Gender-Based Violence (GBV).

**UGANDA OVC CASE PLAN ACHIEVEMENT/GRADUATION BENCHMARKS**  
(LAST UPDATED 16 JANUARY 2018)

<b>PRIORITY AREA – CHILD SURVIVAL AND HEALTH</b>	
<b>KEY OBJECTIVE - INCREASE DIAGNOSIS OF HIV INFECTION</b>	
<b>EXPECTED OUTCOME</b> - Children have known HIV status	
<b>CASE PLAN ACHIEVEMENT/GRADUATION BENCHMARK</b>	<b>MEANS OF VERIFICATION</b>
<ul style="list-style-type: none"> <li>Children and adolescents have HIV status reported to the Implementing Partner, or</li> <li>Children and adolescents have a completed risk assessment indicating that an HIV test is not needed</li> <li>HIV exposed infants (HEI) received a definitive HIV diagnosis following the cessation of breastfeeding</li> </ul>	<ul style="list-style-type: none"> <li>Primary caregiver self-reported HIV test results for child/adolescent</li> <li>For children with HIV status reported as “No Status” by the caregiver who are being considered for graduation, the Case Manager has completed the PEPFAR HIV risk algorithm prototype assessment for child/adolescent showing HIV test not indicated</li> <li>Primary caregiver self-reported HIV results for HEI at least one week after cessation of breastfeeding</li> </ul>
<b>EXPECTED OUTCOME</b> - Primary caregiver has known HIV status	
<ul style="list-style-type: none"> <li>Primary caregiver has reported their HIV status to the Implementing Partner, or</li> <li>Primary caregiver does not demonstrate risk factors for HIV infection</li> </ul>	<ul style="list-style-type: none"> <li>Primary caregiver self-reported HIV test results</li> <li>Primary caregiver self-reported that he/she has not engaged/ experienced any of the following in the past 6 months: <ul style="list-style-type: none"> <li>been diagnosed with TB</li> <li>engaged in risky sexual practices (e.g. sex with a known positive, sex with person with unknown HIV status, sex with multiple partners, transactional sex, sex without condoms)</li> <li>engaged in other risky behaviors (e.g. IDU)</li> </ul> </li> </ul>
<b>KEY OBJECTIVE - INCREASE HIV TREATMENT ADHERENCE, RETENTION AND VIRAL SUPPRESSION</b>	
<b>EXPECTED OUTCOME</b> - HIV+ children and adolescents are virally suppressed - or adherent to ART, if viral load testing is unavailable	
<ul style="list-style-type: none"> <li>HIV+ children and adolescents have an acceptable viral load, or if viral load testing is unavailable, they have attended all appointments regularly, picked up medications, and regularly taken medications for the past 12 months.</li> </ul>	<ul style="list-style-type: none"> <li>ART clinician confirmed that HIV+ child/adolescent is virally suppressed or if viral load testing is unavailable, regularly attending appointments and picking up medications over the past 12 months</li> <li>HIV+ adolescent 12 years and older self-reported that he/she has regularly taken medication without missing doses for the past 3 months.</li> </ul>
<ul style="list-style-type: none"> <li>HIV+ adolescent 12 years and older understands their viral load</li> </ul>	<ul style="list-style-type: none"> <li>HIV+ adolescent over 12 years old could describe their current viral load and correctly defined viral suppression</li> </ul>
<b>EXPECTED OUTCOME</b> - HIV+ primary caregiver is virally suppressed - or adherent to ART, if viral load testing is unavailable	
<ul style="list-style-type: none"> <li>HIV+ primary caregiver has an acceptable viral load, or if viral load testing is unavailable, has attended all appointments, regularly picked up medications and regularly taken medications for at least the past 12 months.</li> </ul>	<ul style="list-style-type: none"> <li>ART clinician confirmed that HIV+ primary caregiver is virally suppressed, or if viral load testing is unavailable, regularly attending appointments and picking up medications over the past 12 months.</li> <li>HIV+ primary caregiver reported that he/she has regularly taken medication without missing doses for the past 6 months.</li> </ul>
<ul style="list-style-type: none"> <li>HIV+ caregiver understands their viral load</li> </ul>	<ul style="list-style-type: none"> <li>HIV+ caregiver could describe their current viral load and correctly defined viral suppression</li> </ul>
<b>EXPECTED OUTCOME</b> - Adolescents 12 years and older know their status and their primary caregiver's status	

CASE PLAN ACHIEVEMENT/GRADUATION BENCHMARK	MEANS OF VERIFICATION
<ul style="list-style-type: none"> <li>• HIV+ adolescents 12 years and older demonstrate appropriate knowledge of their HIV status according to national guidelines</li> <li>• Adolescents 12 years and older demonstrate appropriate knowledge of their HIV+ primary caregiver's HIV status according to national guidelines</li> </ul>	<ul style="list-style-type: none"> <li>• HIV+ adolescent 12 years and older self-reported knowledge of his/her positive HIV status</li> <li>• Adolescent 12 years and older self-reported knowledge of his/her caregiver's positive HIV status</li> </ul>
<b>KEY OBJECTIVE - REDUCE RISK OF HIV INFECTION</b>	
<b>EXPECTED OUTCOME</b> - Adolescents have key knowledge and skills to protect their sexual and reproductive health and prevent HIV infection	
<ul style="list-style-type: none"> <li>• Adolescents can identify sexual and reproductive health/HIV infection risks that they face in their own communities/lives, can describe ways they are protecting themselves against risks, and where they can receive sexual and reproductive health services</li> <li>• Adolescent boys are aware of the protective benefits of medical circumcision against HIV infection and the difference between traditional circumcision and medical circumcision</li> </ul>	<ul style="list-style-type: none"> <li>• Adolescent described at least two sexual and reproductive health/HIV infection risks in his/her local community, one example of how she/ he is protecting himself/herself against risks, and correctly described the location of at least one place where he/she can receive sexual and reproductive health services</li> <li>• Adolescent boy described at least one key fact associated with Voluntary Male Circumcision (VMMC) and at least one key differences between traditional and medical circumcision (e.g. differences in equipment used, cleanliness and disease prevention standards, how much of the foreskin is removed)</li> </ul>
<b>EXPECTED OUTCOME</b> - Adolescents have a relationship with a caregiver or another trusted adult who supports their sexual and reproductive health	
<ul style="list-style-type: none"> <li>• Adolescents had at least one conversation about HIV prevention/sexual and reproductive health with a trusted adult</li> </ul>	<ul style="list-style-type: none"> <li>• Adolescent named at least one trusted adult with whom they feel comfortable discussing HIV prevention/sexual reproductive health topics</li> <li>• Adolescent described date and topic of at least one relevant conversation with a trusted adult about HIV prevention/sexual and reproductive health (Relevant topics may include why to sexual debut, where, how, and why to access sexual and reproductive health services, why to be monogamous or limit sexual partners, why to avoid transactional sex and sex with older partners, and why and how to avoid alcohol and drug abuse)</li> </ul>
<b>OPTIONAL:</b> Adolescent reports to caregiver where he/she goes, what he/she does, and who he/she is with	<b>OPTIONAL:</b> Caregiver can identify the last time the adolescent left the house, where the adolescent went, what the adolescent did, and who the adolescent was with
<b>EXPECTED OUTCOME</b> - Adolescents are not engaging in risky sexual practices	
<ul style="list-style-type: none"> <li>• Adolescents are abstinent</li> </ul>	<ul style="list-style-type: none"> <li>• Adolescent self-reported that she/he is abstinent</li> </ul>
<b>OPTIONAL EXPECTED OUTCOME</b> - Pregnant or new mother living with HIV is preventing mother to child transmission of HIV	
<ul style="list-style-type: none"> <li>• Pregnant or new mother living with HIV attends at least eight ante-natal care appointments and delivers baby at a health facility</li> </ul>	<ul style="list-style-type: none"> <li>• ANC or PNC clinician confirmed that mother is adherent to ANC/PNC protocols</li> </ul>
<b>KEY OBJECTIVE - IMPROVE NUTRITIONAL DEVELOPMENT FOR CHILDREN &lt; 5 YEARS – PARTICULARLY HIV EXPOSED AND INFECTED INFANTS/YOUNG CHILDREN</b>	
<b>EXPECTED OUTCOME</b> - Children < 5 years show no signs of moderate acute malnourishment (MAM) or wasting	
<ul style="list-style-type: none"> <li>• Children &lt; 5 years have a mid-upper arm circumference (MUAC) of no less than 12.5 cm and show no signs of bipedal edema</li> <li>• Children &lt;5 previously treated for malnutrition have z score of &gt; -2</li> <li>• Infants &lt; 6 months are exclusively breastfed</li> </ul>	<ul style="list-style-type: none"> <li>• Case Manager or health worker confirmed that child's mid-upper arm circumference measures over 12.5cm and pressure applied on top of both feet for three seconds and does not leave a pit or indentation in the foot</li> <li>• Clinician previously treating child for malnutrition confirmed that child has a z score of &gt; -2</li> <li>• Mother self-reported that infant &lt;6 months is exclusively breastfed</li> </ul>

KEY OBJECTIVE – IMPROVE MANAGEMENT OF CHILDHOOD ILLNESSES	
EXPECTED OUTCOME - Children are protected against preventable diseases	
CASE PLAN ACHIEVEMENT/GRADUATION BENCHMARK	MEANS OF VERIFICATION
<ul style="list-style-type: none"> <li>Primary caregiver has knowledge of practices that promote child survival, know where children can access immunizations and when their next vaccinations were scheduled</li> <li>Primary caregiver and child have access to safe and clean water and are using appropriate sanitary facilities</li> </ul>	<ul style="list-style-type: none"> <li>Primary caregiver responded appropriately to key questions about practices that promote child survival, growth and development (e.g. Immunization, Breastfeeding, Complementary feeding, Micronutrients, Hygiene, Treated bed nets, Food and fluids, Home treatment, Care-seeking, Adherence, Stimulation, Antenatal care), correctly described the location of at least one place where young children can receive immunizations, and when young children were scheduled to receive their next vaccination</li> <li>Case Worker verifies the existence of safe and clean water and appropriate sanitary facilities</li> <li>Caregiver and child self-reported utilization of safe and clean water and appropriate sanitary facilities by themselves and child</li> </ul>
<ul style="list-style-type: none"> <li>Children have up to date immunizations</li> </ul>	<ul style="list-style-type: none"> <li>Primary caregiver presented up to date immunization cards for children</li> </ul>
<b>OPTIONAL:</b> Children are not currently or recently experiencing illness	<b>OPTIONAL:</b> Primary caregiver self-reported that children did not experience diarrhea or fever in the last two weeks  <b>OPTIONAL:</b> Primary caregiver self-reported that children were not too sick to participate in daily activities in the past two weeks
PRIORITY AREA – ECONOMIC STABILITY AND SECURITY	
KEY OBJECTIVE - INCREASE CAREGIVER'S ABILITY TO MEET IMPORTANT FAMILY NEEDS	
EXPECTED OUTCOME - Caregivers meet the basic needs of children and unexpected household needs	
<ul style="list-style-type: none"> <li>Caregivers have provided a minimum of two balanced and nutritious meals per day to all children and adolescents under his or her care in the past 6 months</li> <li>Caregivers were able to access non-project- related resources to pay for children's and adolescents' food-related expenses incurred in the last four weeks</li> <li>Caregivers were able to access non- project- related resources to pay for children's and adolescents' school-related expenses incurred during the past two school terms</li> <li>Caregivers were able to provide safe shelter to all children and adolescents under their care in the past 6 months</li> <li>Caregivers were able to access non-project- related resources to pay for any unexpected family and/or child-related expenses incurred in the last 6 months</li> <li>Caregiver saves regularly (informally or formally)</li> </ul>	<ul style="list-style-type: none"> <li>Primary caregiver and child/adolescent self-reported eating at least two meals a day for the past 6 months, and describe the key components of a balanced meal</li> <li>Primary caregiver self-reported that the all children's and adolescents' food-related expenses incurred over the past four weeks were paid for by the caregiver using non- project-related resources. Caregiver described the last time he or she bought food for cooking or eating and where the money for the purchase came from.</li> <li>Primary caregiver self-reported that all children's and adolescents' school-related expenses incurred over the past two terms were covered for by the caregiver using non- project-related resources. Caregiver described where payment for the last two school terms for school-age children came from (e.g. household financial resources)</li> <li>Primary caregiver self-reported that all safe shelter-related expenses for the past 6 months were covered for by the caregiver using non-project-related resources. Caregiver described where any related payment came from.</li> <li>Primary caregiver self-reported that the all unexpected expenses incurred over the past 6 months were covered by the caregiver. Caregiver described the last unexpected expenses incurred, such a as a house repair or urgent medical treatment, and where the money to pay for the expense came from.</li> <li>Caregiver self-reported saving money each month for the past three months</li> </ul>
OPTIONAL EXPECTED OUTCOME - Caregivers have access to income and savings	
<b>OPTIONAL:</b> Caregiver has had access to at least one reliable source of income for the past three months <b>OPTIONAL:</b> Caregiver has access to household savings	<b>OPTIONAL:</b> Caregiver or household member self-reported earning money from a productive activity for the past three months <b>OPTIONAL:</b> Caregiver self-reported household savings
OPTIONAL KEY OBJECTIVE – INCREASE ACCESS TO BASIC SHELTER	



<b>OPTIONAL EXPECTED OUTCOME</b> - Children have access to basic shelter	
<b>OPTIONAL:</b> Children sleep in a safe place	<b>OPTIONAL:</b> Primary caregiver and children (or child only if there is no caregiver e.g., children in street situations) identified the place where children sleep and demonstrated that it is safe from weather / natural hazards (e.g. is structure adequate to keep the child dry and warm, i.e. hypothetically, if it had rained last night, would the child have been kept dry in the place they slept?), secure from destruction and unwanted entry, with access to adequate sanitation and not in a dangerous location
<b>PRIORITY AREA – CHILD CARE AND PROTECTION</b>	
<b>KEY OBJECTIVE - REDUCE RISK OF PHYSICAL, EMOTIONAL AND PSYCHOLOGICAL INJURY DUE TO EXPOSURE TO VIOLENCE, GBV SEXUAL ABUSE, CHILD LABOR OR ECONOMIC ABUSE</b>	
<b>EXPECTED OUTCOME</b> - Children over age 8 years, adolescents and caregivers are not experiencing violence	
<ul style="list-style-type: none"> <li>Children over age 8 years, adolescent and caregivers can define abuse, neglect, and exploitation</li> <li>Children, adolescents and caregivers have not experienced abuse, neglect, or exploitation in the last six months.</li> </ul>	<ul style="list-style-type: none"> <li>Children over 8 years, adolescent and caregiver provided at least one example of (1) child maltreatment, (2) intimate partner violence, (3) sexual violence and (4) emotional or psychological violence (e.g. definition on page 14 of the INSPIRE: Seven strategies, also see annex)</li> <li>Children over 8 years, adolescent, and caregiver self-reported no experiences abuse, neglect, or exploitation for themselves and children under 8 years in their care in the past 6 months in response to questions about experiences</li> </ul>
<b>EXPECTED OUTCOME</b> - Children, adolescents, and caregivers who have experienced violence receive appropriate violence response services	
<ul style="list-style-type: none"> <li>Children, adolescents and caregivers who have experienced violence have received a minimum package of multi-sectoral services: medical/forensic, safety/protection, psychological, legal/justice, and other supports, depending on the context</li> </ul>	<ul style="list-style-type: none"> <li>Caregiver provided evidence of multi-sectoral services received, including medical, legal, safe shelter, and psychosocial services (e.g. returned referral slips, caregiver and children/adolescents reported service received, or service providers confirmed serviced received)</li> </ul>
<b>EXPECTED OUTCOME</b> - Children, adolescents, and caregivers know how to access appropriate violence response services	
<ul style="list-style-type: none"> <li>Children, adolescents, and caregivers can describe steps to take after experiencing violence – including where and how to seek services</li> </ul>	<ul style="list-style-type: none"> <li>Primary caregiver, child over 8 years, and adolescent described where and how to access (1) medical, (2) legal, (3) safe shelter, and (4) psychosocial services in their community</li> </ul>
<b>EXPECTED OUTCOME</b> - Children and adolescents are under the care of a stable adult caregiver	
<ul style="list-style-type: none"> <li>Children and adolescents have been under the care of and lived with the same, stable adult primary caregiver for at least 12 months</li> </ul>	<ul style="list-style-type: none"> <li>Caregiver identified by child/adolescent as his/her primary caregiver confirmed that he or she is an adult (over 18 years old), and has cared for and lived in the same home as the child/adolescent for at least the last 12 months</li> </ul>
<b>KEY OBJECTIVE - INCREASE ABILITY AMONG CHILDREN TO ACCESS BASIC SUPPORT</b>	
<b>KEY OUTCOME</b> - Caregivers, adolescents and children can access basic support	
<ul style="list-style-type: none"> <li>Caregivers, adolescents and children can identify someone in their lives to turn to for suggestions about how to deal with a personal problem, to access information about a health or child protection issue, to help with daily chores if they were sick, to do something enjoyable with, and who shows them love and affection</li> <li>Children and caregivers who have experienced violence are not showing signs or symptoms of trauma or depression</li> </ul>	<ul style="list-style-type: none"> <li>Caregiver, adolescent and children can name someone who they can turn to (1) for suggestions about how to deal with a personal problem, (2) for information about a health or child protection issue, (3) for help with daily chores if they were sick, (4) for love and affection, (5) for doing something enjoyable with</li> <li>Caregiver and teachers confirmed that child/adolescent does not exhibit the following behaviors: (a) extreme sadness all the time, (b) withdrawn behavior, (c) not engaging in play or enjoyable activities, (d) lack of appetite for food, (e) other signs of depression.</li> </ul>

<b>KEY OBJECTIVE – IMPROVE LEGAL STATUS</b>	
EXPECTED OUTCOME - Children and caregivers have legal identification documents	
<b>CASE PLAN ACHIEVEMENT/GRADUATION BENCHMARK</b>	<b>MEANS OF VERIFICATION</b>
<ul style="list-style-type: none"> <li>Children and caregivers have birth certificates or other identification (ID) card issued by appropriate Government authorities</li> </ul>	<ul style="list-style-type: none"> <li>Caregiver presented birth certificates or other identification cards</li> </ul>
<b>PRIORITY AREA – EDUCATION AND DEVELOPMENT</b>	
<b>KEY OBJECTIVE - INCREASE SCHOOL ATTENDANCE</b>	
EXPECTED OUTCOME - School-age children and adolescents regularly attend and complete educational programs	
<ul style="list-style-type: none"> <li>School-age children and adolescents are enrolled in school, attend regularly and complete major education cycles</li> <li>Adolescents enrolled in structured livelihoods development activities attend regularly and complete the livelihoods development activity program</li> </ul>	<ul style="list-style-type: none"> <li>School administrator confirmed that school-age child/adolescent is enrolled in school and has not missed more than 5 days per month in the last 6 months</li> <li>Administrator of a livelihoods activity (e.g. facilitator of technical or vocational training course or master trainer for an apprenticeship program) confirmed that adolescent did not miss more than 5 days per month in the last 6 months</li> <li>If the school-age child and adolescent has not completed their education cycle/livelihoods development activity before the program ends, and they need further support to complete, the child/adolescent is transferred to another program to ensure this support until completion</li> </ul>
OPTIONAL EXPECTED OUTCOME - Preschool-age children regularly attend preschool programs	
OPTIONAL: Preschool-age children are enrolled in preschool and attend regularly	OPTIONAL: Preschool administrator confirmed that preschool-age child is enrolled in preschool and has not missed more than 5 days per month in the last 6 months
<b>KEY OBJECTIVE – INCREASE SCHOOL PROGRESSION</b>	
EXPECTED OUTCOME: School-aged children and adolescents have demonstrated expected progression over the last school year	
<ul style="list-style-type: none"> <li>School-age children between ages 6-17 progressed from one grade to the next grade in the last year</li> <li>Adolescents enrolled in a vocational training course or apprenticeship program progressed from one level to the next level or graduated in the last year</li> </ul>	<ul style="list-style-type: none"> <li>School administrator confirmed that child/adolescent between ages 6-17 progressed from one grade to the next grade or graduated in the last school year</li> <li>Administrator of a vocational training course or master trainer for an apprenticeship program confirmed that adolescent progressed from one level to the next level or graduated in the last year.</li> </ul>
<b>KEY OBJECTIVE - IMPROVE DEVELOPMENT FOR CHILDREN &lt; 5 YEARS – PARTICULARLY HIV EXPOSED AND INFECTED INFANTS/YOUNG CHILDREN</b>	
EXPECTED OUTCOME - Primary caregiver of HIV exposed and infected infants/young children is promoting early childhood stimulation	
<ul style="list-style-type: none"> <li>Primary caregiver of HIV-exposed and infected infants and children under 5 years can describe examples of how and when household members engaged in early childhood stimulation with infants/children in the last week.</li> </ul>	<ul style="list-style-type: none"> <li>Primary caregiver demonstrated at least one recommended early childhood stimulation activity</li> <li>Primary caregiver self-reported at least one date/time in the last 3 days when the caregiver or any household member over age 15 engaged in early childhood stimulation with infants/young children</li> </ul>



# STEP 5

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## DIRECT SERVICE PROVISION AND REFERRAL





## CM STEP 5 – STANDARD OPERATING PROCEDURE FOR DIRECT SERVICE PROVISION AND REFERRALS

### WHAT:

In this fifth step of the CM process, the Case Worker begins to act on the case plan that he/she has completed with the caregiver, child or adolescent. Specifically, the Case Worker, PSWO or CDO determines the needs that the child/adolescent and caregiver cannot address on their own and which programme services will be provided either directly or through referral.

Depending on the OVC programme, services may be provided by the Case Worker, PSWO or CDO. This is called “direct service provision.” Examples of services that a Case Worker, PSWO or CDO may provide include information or trainings on hygiene or parenting. A very important service that all Case Workers, PSWO or CDO provide is psychosocial support. This support is the result of routine, friendly interactions with members of the household through regular CM meetings. Spending time with children and their families, and simply providing support through Case Workers’ presence and attention, can contribute to the household members’ overall well-being.<sup>8,9</sup>

**Spending time with children and their families, and simply providing support through Case Workers’ their presence and attention, can contribute to the household members’ overall well-being.**

Because individual OVC programmes do not typically have all the resources or expertise to provide all the services that a child and his/her household may require, a Case Worker, PSWO or CDO may refer a child and/or household to another organization for some services (e.g., cash assistance, positive parenting, savings and loan groups, health care, legal aid, GBV counseling, disability rehabilitation, psychosocial support and care). In these situations, a system for tracking and monitoring referrals is necessary to ensure that referrals are effective, and that children and families are receiving the services they need to meet their goals.<sup>13</sup>

OVC programmes should consider referrals at four levels: the national or IP level; the region or local IP level; the community level; and the case level (see Figure 2 on the next page).

**WHO FACILITATES:** The MDAs, PSWOs, CDOs, Parish Chiefs and IP staff.

- 1. At the national or programmatic level,** an OVC programme must work closely with other key stakeholders whose engagement is critical. These stakeholders can be governmental, nongovernmental, or faith-based and can include, for example, the Ministry of Health and health facilities at the national level; the MGLSD; Child Protective Services; and other relevant social service providers. Conducting a rapid mapping of who these players are at the national level is an important part of programme design and implementation. That the service providers are aware of the OVC programmes, the target population, and the need for effective referrals should be discussed, agreed upon, and outlined in a Memorandum of Understanding (MOU). This MOU will recognize the key roles of other actors in supporting the provision of a range of services for OVC and will hopefully facilitate referrals at the individual case and IP level.
- 2. At the regional or local IP level** (i.e., the sub-county, district, or regional level), the IP must also conduct a service mapping,<sup>10</sup> establish and formalize (via an MOU) the relationships with key service providers, organize and/or participate in relevant meetings or case conferences, and ensure that the goals and approaches of the OVC programme are clearly articulated and understood by the service providers at this level.

<sup>8</sup> Global Protection Cluster Child Protection; European Commission Humanitarian Aid; USAID. 2014. Inter-Agency Guidelines for Case Management & Children Protection. [http://www.cpcnetwork.org/wp-content/uploads/2014/08/CM\\_guidelines\\_ENG\\_.pdf](http://www.cpcnetwork.org/wp-content/uploads/2014/08/CM_guidelines_ENG_.pdf) (accessed September 14, 2018).

<sup>9</sup> Save the Children. 2011. Case Management Practice within Save the Children Child Protection Programmes. Retrieved from <http://www.socialserviceworkforce.org/system/files/resource/files/Case%20Management%20Review.pdf> 13 Save the Children. 2011. Op cit.

<sup>10</sup> Service mapping provides the foundation for a referral mechanism. In service mapping, information about services (public and private) and other sources of support (such as a youth or mother’s club) in a specific geographic area is collected and shared.

<b>National or Implementing Partner Level</b>	<ul style="list-style-type: none"> <li>• National-level Ministries of Health, Education, Social Welfare, and Child Protection, and the implementing partner</li> <li>• MOUs, participation in national-level working groups, articulation and understanding of the approaches and goals of the OVC programme</li> </ul>
<b>Regional sub-county, district or Local Implementing Partner Level</b>	<ul style="list-style-type: none"> <li>• Regional representation of the Ministries of Health, Education, Social Welfare and Child Protection, nongovernmental organizations, the private sector, and local implementing partners(s)</li> <li>• MOUs, participation in relevant working groups, child protection networks or committees, articulation of approaches and goals of the OVC programme</li> </ul>
<b>Community Level</b>	<ul style="list-style-type: none"> <li>• Teachers, community leaders, etc.</li> <li>• Peer support groups, including children and adolescent clubs</li> <li>• Faith-based actors</li> <li>• Child protection or health committees</li> <li>• Savings and loan groups, parenting groups, etc.</li> </ul>
<b>Individual Case Level</b>	<ul style="list-style-type: none"> <li>• PSWO, CDO, Parish Chief, Case Worker, Case Manager, members of the OVC household, local service providers, and community members</li> <li>• SOPs for referral, referral tool, case conferencing</li> </ul>

One way of facilitating cross-sectoral referrals for OVC at this level is through establishing regular case conferencing meetings that engage the relevant service providers and OVC programme representatives.

**3. At the community level,** the local implementing partner should identify relevant service providers, such as health providers, parenting groups, child and adolescent clubs or support groups, safe spaces, savings and loan groups, and faith-based initiatives, as well as organizations that identify and refer child protection concerns/cases, such as child protection committees, teachers and other school staff, and health sector and faith-based actors. Ensuring that these service providers are identified and informed of the OVC programme and that an MOU has been established are critical first steps to establishing a strong referral system.

**4. At the individual case level,** the need for referrals is identified when conducting the assessment and developing the case plan and/or when monitoring case plan implementation. The Case Worker should identify the service(s) needed, discuss with the members of the household, then follow the SOPs for service provision and use the Service Referral Form for making a referral. It is very important to remind all of those engaged in the referral process that a referral does not really add value until it is completed. Case conferencing can also occur at this level when there is an especially challenging set of circumstances (see SOP for Case Conferencing for more information on individual case-level conferencing).

#### TOOLS:



- Completed CM Step 4 **Tool I:** Case Planning with Caregivers, Children 8 - 11 years and Adolescents aged 12-17 years (OVCMIS FORM 012A)
- Completed CM Step 5 **Tool I:** Service Provision and Referral Form (OVCMIS FORM 009)

#### WHO FACILITATES:

The PSWO/CDO/Case Worker/Case Manager facilitate.

#### WHO PARTICIPATES IN THE REFERRAL PROCESS:

All members of a household participate as well as representatives from service providers to which a household, child, or adolescent is referred.

## HOW: The Case Worker should:

1. Complete (based on the needs, strengths, and assets identified in the assessment and the goals set in the case plan) sections 1, 2, 3, and 4 of the Service Provision and Referral Form for services that the OVC programme cannot provide directly. While completing the form, the Case Worker should engage the child and caregiver or adolescent to ensure that they are part of the decision-making process and are engaged in following up on the referral.
2. Record on the Case Plan all individuals, organizations, and government services that should be or have been contacted or referred to.

## Members of the household or unaccompanied child should then:

1. Take the Service Referral Form to the service provider to whom the household, unaccompanied child or adolescent was referred and receive the service. **NOTE: If the child and/or caregivers do not take the referral form to the receiving service provider, the Case Worker should meet with the family to discuss why. In some cases, the Case Worker may need to escort the child and caregivers to the service provider or work with the family or unaccompanied child to address challenges related to transport.**

## A representative from the service provider receiving the referral should:

1. Provide the service outlined in the referral.
2. Complete Section 5 of the Service Referral Form. He/she should maintain a record of it in the service provider's files and send the client back with a duplicate copy.
3. Regularly engage with the PSWO, CDO, Case Worker /Case Manager or Approved Home Warden (if it exists) to ensure that referrals are being completed in a timely and effective manner.
4. Participate in case conferences on as-needed basis.

## Lastly, the Case Worker of the referring organisation / institution should:

Check during the caregiver's/child's/adolescent's next visit if the service was provided, what the result was, and then document that information in the case file using the bio-data in the service provision and referral form (OVC MIS 009)



## **CM STEP 5 – STANDARD OPERATING PROCEDURE FOR CASE CONFERENCING**

### **WHAT:**

A case conference in child programming is a formal, planned, and typically multidisciplinary meeting usually convened by PSWO/CDO involving service providers from a variety of fields involved in the care of a child and/or household, with the aim of reviewing service options across sectors and agencies and making decisions with the best interests of the child in mind. Case conferencing brings together service providers from different backgrounds and sectors that, through their expertise and experience, can understand and discuss a complex problem from a range of perspectives and identify unique solutions that are tailored to the individual case. This inter-agency discussion is intended to help to clarify the child's and household's situation, gain agreement regarding the best way to proceed, and make needed adjustments to the case plan. Case conferences can take place any time throughout the CM process from assessment to case planning to monitoring to case closure.

### **TOOLS:**



• CM Step 5 **Tool 2:** Case Conference Form (OVCMIS FORM 013)

### **WHO FACILITATES:**

The senior PSWO, CDO, can call a case conference on behalf of multiple stakeholders involved in child programming in their area of jurisdiction. Upon receiving complex, difficult or delayed cases requiring urgent or emergency multi-sectoral response.

### **WHO PARTICIPATES:**

An inter-agency or multisectoral team is assembled to provide input and develop a case plan as a team. Representatives from each organization/group of the multisectoral team should attend to ensure that each person is aware of who is responsible for following through on which action and/or referral. Everyone in attendance should sign a **Confidentiality Agreement Form** (figure 2 on following page), which can also be found in the additional guidance on data protection protocols.

Before a senior PSWO/CDO call a case conference, they should familiarize themselves with the case and determine if it is appropriate for the child or caregiver to attend the conference.

### **HOW:**

**In preparation for the case conference, the senior PSWO/CDO in collaboration with the Case Managers and Case Workers should:**

1. Arrange a time and place for the case conference when they feel that a case or multiple cases would benefit from a conference. They should invite only those who are pertinent to the case(s).
2. Review the case file(s) prior to the conference.
3. Based on the information above, narrow down the issues to the main ones they want to discuss during the meeting. It is often helpful to put these on a flip chart, white / blackboard, or screen to stay focused. They should also bring the case file(s) to the case conference, respecting confidentiality and data protection protocols.
4. **Only complex cases** should be presented for case conferencing

### **At the case conference:**

5. Everyone attending should sign the **Confidentiality Agreement Form** upon arrival. No confidential information should be shared until everyone has signed.
6. The PSWO/CDO should convene the case conference and welcome and introduce all participants.
7. The PSWO/CDO should present the objectives of the case conference and agenda items, including the cases that will be presented in detail for discussion.

8. The Case Manager or Case Worker should present the details of the case (or cases) for discussion. He/she should highlight the processes that took place (from identification, assessment, case plan development, to any referrals and monitoring visits conducted) and the challenging area(s) in which he/she requires input from the case conference participants. For cases brought to the conference after case planning, the PSWO/CDO should highlight the actions in the case plan and what has been done on those actions. The conversation should be respectful of clients and their privacy, and if other agencies are involved, as little information as is necessary for the point of discussion should be shared, and no more.
9. The PSWO/CDO should allow participants to share experiences in handling similar cases, while ensuring confidentiality is respected. This sharing enriches the discussion and provides an opportunity for learning.
10. After discussions, the case conference members should agree on actions to be undertaken, by whom, and by when.
11. The PSWO/CDO should keep minutes of the meeting, including decisions and assignments made, as well as follow-up actions to be taken. **After the case conference:**
12. The Case Worker should summarize the proceedings of the case conference using the **Case Conference Form** and include it within the family's, adolescent's or unaccompanied child's case file. Action steps, persons responsible, and a timeline for completing the action steps should be documented on the **Case Plan Form**.
13. The PSWO/CDO should send the minutes summarized in the **Case Conference Form** to the attendees for use in follow-up.
14. The PSWO/CDO should plan a follow-up case conference to assess progress towards agreed-upon actions.
15. if necessary, the caregiver, child or adolescent should be invited to attend the meeting.

**Figure 2:**

## CONFIDENTIALITY AGREEMENT

(for case conferences)

### ACKNOWLEDGEMENT OF CONFIDENTIALITY OF FAMILY AND CLIENT INFORMATION

I agree to treat as confidential all information about all children and their families that I learn during the performance of my duties as \_\_\_\_\_ (official position / title) and member of the case conference. I understand that it is a violation of policy to disclose such information to anyone outside the case conference membership.

NAME OF MEMBER: \_\_\_\_\_

SIGNATURE OF MEMBER: \_\_\_\_\_

DATE: \_\_\_\_\_

*It should be noted that while the above form is specifically about confidentiality of information received during case conferencing meetings, a similar approach can be used for all levels of data collection, sharing, and management.*



# STEP 6



## MONITORING

6



## CM STEP 6 – STANDARD OPERATING PROCEDURES FOR MONITORING

### Ongoing Monitoring and Monitoring of Case Plan Achievement

#### WHAT:

Monitoring is a process that involves meeting with: the members of a household, including the caregiver(s) and child(ren) (often via routine home visits); service providers to whom the household has been referred; and others who regularly interact with the child or caregiver to determine if and how the case plan is being implemented. Monitoring also allows the Case Worker and Case Manager to track the likelihood that the goals and related actions of the case plan will be achieved.

During monitoring visits to the child and caregiver's home, the Case Worker should identify through interviews and observation any changes to the child or caregiver's circumstances, review the case plan to determine which actions have been completed and any challenges faced in completing actions, and also raise any concerns or highlight achievements noted by service providers or others who regularly interact with the child or caregivers. He/she should work with the child and caregiver to solve any problems or concerns preventing the achievement of the case plan goals, address any emergency concerns, make changes to the case plan as appropriate (e.g., adding, eliminating, 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. Lastly, he/she should document the visit by completing an Ongoing Monitoring Form and placing it in the household's case file.

The frequency of monitoring may vary depending on the level of need and the interventions required. For example, a household with urgent needs should receive frequent, regular home visits, such as on a weekly basis. For households that are doing well and nearing case plan achievement, visits may take place on a monthly to quarterly basis. To be counted as an "active beneficiary" under some programs such as a PEPFAR-funded OVC programme, Case Workers must meet with a child and caregiver at least quarterly.

For particularly complex cases, PSWO/CDO may organize what is called a case conference (see Step 5 for more details).

**This SOP describes two different types of monitoring that are both part of the monitoring process: 1) Ongoing monitoring and 2) periodic monitoring of vulnerability among Households, Children aged 8-11 years and Adolescents 12-17 years.**

#### I. On-going monitoring of the case plan

#### WHAT:

This type of monitoring occurs during regularly scheduled visits conducted by the Case Worker immediately after the case plan is developed. The Case Worker and Case Manager determine the frequency of monitoring visits depending on the needs of the case. It is recommended that families be visited at a minimum of once a month for the first 3 months of case plan implementation and again between the sixth and ninth month. This tool must not take the place of HVAT and AVAT which are administered at the sixth and twelfth months of case plan implementation. The ongoing monitoring tool is used to monitor progress of the household/adolescents towards progress.

#### TOOLS:



- Completed CM Step 4 **Tool 1:** Case Planning with Caregiver, children 8-11 years and adolescents 12-17 years (OVCMIS FORM 012A)
- Completed CM Step 4 **Tool 4:** Summary of Key Priority Actions to Share with the Household/adolescents (OVCMIS FORM 012B)
- CM Step 6 **Tool 1 :** Ongoing Monitoring Form (OVCMIS FORM 014A)
- CM Step 6 **Tools 2 & 3:** The Household Vulnerability Assessment Tools (HVAT) FORM (007A) and (AVAT) FORM (007B)
- CM Step 6 **Tool 4:** OVC Household Home Visit Form (OVCMIS FORM 014B)
- CM Step 6 **Tool 4:** Quarterly Report Form (OVCMIS FORM 100)

**WHO FACILITATES:**

The Case Worker with support from the PSWO/CDO/Case Manager facilitates.

**WHO PARTICIPATES:**

All members of the household participate.

**HOW:****The Case Worker should:**

1. Monitor the household for a period of three to six months after inception of case plan implementation.
2. Visit the household at the day and time agreed upon in the case plan. During this visit, the Case Worker should frame the conversation with household members using the agreed-upon goals and actions outlined in the case plan. Discussions should focus on what has gone well for the household since the last visit; what actions have been achieved and by whom; which actions have not been achieved and why; and any other pertinent issues. All information should be marked in the case plan (i.e., in the notes column or the tick box for completed actions).
3. Discuss, during subsequent visits with the caregiver, child or adolescent either at home or at another location (i.e., at a support group meeting), their progress towards meeting the goals outlined in the case plan (which also align with the Uganda Case Plan Achievement Benchmarks/Indicators for OVC Programming).
4. Note in the case plan any emergency issues that arise during the visit (e.g., malnutrition, changes in HIV status or care and treatment plan, or child protection concerns, GBV, disability ); related actions must be taken immediately. The Case Worker must also alert the Case Manager and other relevant actors. The Case Worker should follow up or make new referrals to other service providers if needed, using the Service Provision and Referral Form (OVCMIS FORM 009).
5. Record notes that include: the date of the next visit, whether or not the household is on track, any changes in the case plan that need to be made, and any direct support provided by the Case Worker, following every visit with the household. The member of the household and the Case Worker should sign or provide their thumb print on the Summary of Key Priority Actions to Share with the Household or the adolescent on the Summary of Key Priority Actions to Share with the Adolescent.

**Step 6: Tool 2 Household Vulnerability Assessment Tool-HVAT (OVCMIS FORM 007A)**

The Household Vulnerability Assessment Tool (HVAT) is also used to monitor the transition in vulnerability within the households supported. The tool should only be used at this stage with HHs that are enrolled onto programmes and have been receiving support based on a case plan developed together with the service provider. The tool should be applied for monitoring after six months, at the end of 12 months, at the end of a support programme, and/or as frequently as it may be required for monitoring. It is recommended that for assessment for readiness for graduation, the interviewer should find additional information and/or validate critical information from other sources like schools, health facilities, OVC service providers, community leaders, village health team members, and para-social workers, among others in line with the questions in the HVAT.

**Step 6: Tool 3 Adolescent Vulnerability Assessment Tool (AVAT) for Adolescents Aged 12-17 Years (OVCMIS FORM 007B)**

The Household Vulnerability Assessment Tool (AVAT) for adolescents is also used to monitor the transition in vulnerability among adolescents supported. The tool should only be used with adolescents who are enrolled onto programmes and have been receiving support based on a case plan developed together with the service provider. The tool should be applied for monitoring after six months, at the end of 12 months, at the end of a support programme, and/or as frequently as it may be required for monitoring. It is recommended that for assessment for readiness for graduation, the interviewer should find additional information and/or validate critical information from other sources like schools, health facilities, OVC service providers, community leaders, village health team members, and para-social workers, among others in line with the questions in the AVAT.

## 2. Periodic monitoring of vulnerability among Households, Children and Adolescents.

The Vulnerability Assessment Tools (HVAT) OVCMIS FORM (007A) and AVAT OVCMIS FORM(007B) and the graduation Benchmarks/ Indicators highlighted in the case planning step 4, provide the criteria against which a household can be measured to determine if it is reaching or has reached the case plan achievement. Uganda Case Plan Achievement Benchmarks/ Indicators for OVC Programming are objectively verifiable measures that help track progress towards the achievement of the goals in the family case plan, which include the overall goals of OVC programming as well as the identified goals of the household. The benchmarks are categorized into four priority areas and each has between one and seven specific benchmarks. The priority areas are:

- 1. Survival and health:** This priority area includes interventions to support the achievement of health outcomes build health and nutrition knowledge and skills in caregivers and facilitate access to key health services, especially HIV testing, care and treatment services that enable vulnerable children especially girls o stay HIV-free.
- 2. Economic stability and security:** This priority area includes interventions that reduce economic vulnerability and increase resiliency in adolescents and families vulnerable and affected by HIV and other adversities.
- 3. Care and protection:** This priority area includes interventions to prevent and mitigate violence against, abuse, exploitation and neglect of children and adolescents including sexual and gender-based violence
- 4. Education and development:** This priority area includes interventions support children and adolescents affected by HIV to overcome barriers to access education, including enrolments, attendance, retention and progression and /or transition<sup>11,12</sup>. It also addresses vocational training in the case of some adolescents as well as the aspects of integrated early childhood development such as early childhood stimulation activities.

To reach case plan achievement, an OVC household must successfully meet all of the graduation benchmarks/ indicators.

It is recommended that an OVC program assesses case plan achievement readiness for households, young children and adolescents using the Vulnerability Assessment Tools (HVAT) OVCMIS FORM (007A) and AVAT OVCMIS FORM(007B) respectively after a case plan has been implemented for at least the first six months and thereafter on a quarterly basis. This will allow ample time to ensure that all actions outlined in the case plan have been successfully completed. A program can decide how the case plan readiness assessment can be conducted. This could be done for all cases within the program (i.e. en masse) or for only those cases that via their case plan documentation and on-going monitoring they have been identified as households likely to be reaching case plan achievement. This decision should be made based on case file data, the financial and human resources available and the goals of the programme.

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<sup>11</sup> Ibid

<sup>12</sup> PEPFAR. 2015. Technical Considerations Provided by PEPFAR Technical Working Groups for 2015 COPs and ROs





## CM STEP 6: SOP ON GUIDING QUESTIONS FOR PREPARING A HOUSEHOLD FOR CASE PLAN ACHIEVEMENT (OR SERVICE EXIT)

### Celebrating the Success of Case Plan Achievement

#### FOR CAREGIVERS AND CHILDREN BELOW 12 YEARS:

1. Let's review your goals as a family, how do you feel about having reached them?
2. In your opinion, what did you do that helped you reach your goals? Was there anyone who helped you whom you think was critical?
3. How do you think you could help other families or children like you to become like you, a strong, caring and healthy family?

#### FOR THE CAREGIVER:

1. How do you feel about having built your own strengths to be able to take care of the children in your family?

#### FOR THE ADOLESCENT AGED 12-17 YEARS:

1. What accomplishments are you proud of? For example, is it being able to go to school, staying healthy, being part of a caring family?

### Identifying remaining questions or worries

#### FOR CAREGIVERS, CHILDREN BELOW 12 YEARS AND ADOLESCENTS:

As we discussed, you are soon going to graduate from the program, which means thanks to your hard work, you are able to be a stable family and no longer require the activities or services that were provided by \_\_\_\_\_ (give the name of organization / institution). How do you feel?

Are there any questions you would like to discuss with me that you are thinking about for after you have graduated from the program? For example, is there something that worries you?

### Developing some simple steps to support the household post-graduation

#### FOR CAREGIVERS, CHILDREN BELOW 12 YEARS AND ADOLESCENTS:

1. Before you leave the program **[provide name of organization]**, I would like to give you my phone number. I think you already have it but I would like to make sure you have it in case if you need it. Would you like my phone number?
2. Some families who graduated before have found it useful to meet with another family that graduated a year ago. Would you like to meet another family who graduated from the program?
3. As you know our organization **[provide name of organization]** is always in the community. In addition to me, do you know others in the organization who can help you if you need?



## CM STEP 6: TOOL 4 QUARTERLY REPORT (OVCMIS FORM 100)

**OBJECTIVE:**

Reports quarterly numbers of OVC and OVC households provided services

**TIMING:**

Due 15th October; 15th January; 15th April; 15th July

**RESPONSIBILITY:**

Parish Chief / Case Manager Organization/ Institution Manager

**PROCEDURE:**

1. All OVC Service Provider Organization/Institution must compile and submit the OVCMIS Quarterly Report (OVCMIS Form 100). The Report consists of 6 sections as follows;

**Section 1:** Shows a summary of economic strengthening support provided to OVC, this includes; IGA's (piglets, goats, seeds etc.), special microfinance credit, market linkages among others.

**Section 2:** Gives a summary of OVC and OVC households supported to access safe water, health services and shelter. It Summarizes the agricultural and nutritional support provided to OVC and OVC households.

**Section 3:** Summarizes the education support provided to OVC, this support includes; School fees and other scholastic materials (pens, books, uniform etc.). I also summarizes psychosocial and basic care support provided to OVC within the quarter. Psychosocial support includes counseling, recreation activities for OVC, will and memory book writing while basic care support includes clothing and beddings, assistive devices for disabled and palliative care for HIV+ children

**Section 4:** Gives a summary of protection and legal aid provided to OVC.

**NOTE:** Birth registration is the official recording of a child's birth by the government. It establishes the existence of the child under law and provides the foundation for safeguarding many of the child's rights and to be registered at birth without any discrimination. Birth registration is central to ensuring that children are counted and have access to basic services such as health, social security and education. It is central to protecting them from child labour, being arrested and treated as adults in the justice system, forcible conscription in armed forces, child marriage, trafficking and sexual exploitation. A birth certificate is proof of birth. Improved birth registration records contribute to statistical data that are crucial for planning, decision making and monitoring actions and policies aimed at protecting children such as the National Identification Registration. Children that register for National identification are issued a National Identification Number (NIN) by the National Identification and registration Authority (NIRA) that can be confirmed Online.

**Section 5:** Summarizes the number of OVC supported with 3 or more CPAs, referred for other services, of HIV+ children supported, number of staff trained in OVC programming e.g. training in psychosocial support services, M&E, Child protection, proposal writing, coordination and referral etc. This section also reports the number of community volunteers trained, these volunteers include paralegals, child protection committees, child rights advocates, child mediators etc.

This section is also used to summarize data on the total number of OVC served in the quarter, OVC newly enrolled in the quarter, number graduated in the quarter, number of sensitization activities/ events conducted, number of households assessed in the quarter, number considered for support and OVC identified in the households considered for support.

**Section 6:** This section is used to summarize data on HIV Testing Services (HTS) provided to OVC in the quarter i.e. OVC referred for HTS, OVC Tested for HIV, OVC Tested HIV+, OVC linked to HIV Care & Treatment etc....

**Section 7:** This section is used to summarize data on the OVC HIV Status e.g. OVC Reported HIV Negative Status, OVC who report HIV Positive Status, OVC with Unknown HIV status, HIV+ OVC currently on ART Treatment etc..on ART Treatment etc.



# STEP 7

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CASE CLOSURE AS A RESULT  
OF CASE PLAN ACHIEVEMENT,  
TRANSFER, OR ATTRITION





## CM STEP 7 – STANDARD OPERATING PROCEDURES FOR CASE TRANSFER

### WHAT:

Transfer is the process of supporting the movement of a child and/or household from active participation in a given OVC programme to another source of CM support. Transfer is appropriate when a child is on the verge of aging out of a programme or a household moves outside the OVC programme's catchment area before interventions recommended in the case plan have been implemented. Also, transfer may be appropriate if the OVC programme is relocated to a different area, closed, or its scope and funding are reduced before the members of the household have achieved their case plan goals.

### TOOLS:



• CM Step 7 **Tool 1:** Case Transfer Plan

(OVC MIS FORM 015)

### WHO FACILITATES:

The Case Worker together with the PSWO, CDO, or Case Manager facilitate.

### WHO PARTICIPATES:

All members of the household and other service providers deemed appropriate participate.

### HOW:

#### The Case Worker should:

#### 1. Develop a Case Transfer Plan:

- Identify additional ongoing household needs and resources. The Case Worker together with the Case Worker/ Case Manager may identify the child and household's specific needs, strengths, and assets by reviewing their assessments and case plan. From this review, the Case Worker should compile a list of children and households that require ongoing support and a general description of the type of support required.
- Identify sources of support or other support organizations. The Case Worker and the PSWO/CDO/Case Worker/ Case Manager should utilise existing networks of service providers or those identified through service mappings to identify appropriate service providers to which the case may be transferred.
- The PSWO/CDO/Case Worker/Case Manager and/or the IP representative should develop an MOU with alternate/new service providers that are able and willing to accept transferred cases. The MOU should outline details such as which cases will be transferred, how the transfer will take place, and the services that will be provided.
- Plan the transfer with all members of the household. The Case Worker and/or PSWO/CDO/Case Worker/ Case Manager should explain the transfer process to the household, describe the services that will be provided by the new service provider, and describe any final assistance that the current OVC programme will provide. The members of the household should also be given the option to accept new services or exit the programme without transfer. In this situation, the case should be closed.
- Conduct a final case plan review. The Case Worker should meet with all members of the household one final time to review their achievements and respond to any concerns or other feelings associated with exiting the given OVC programme.

#### 2. Implementing the Case Transfer Plan:

- Introduce the family to the new service provider and review the household members' case plan and family folder with the new Case Worker.

The OVC programme should formally transfer copies of the family file folders in a confidential and organized manner. The original copy of the family file folder should stay at the transferring organization to have a record of the service it provided.

- The PSWO/CDO/Case Worker/Case Manager should follow up with and support the new service provider to ensure that the child and household can achieve their goals and become more resilient. Follow-up can take place in the form of regular calls. The time and frequency of the follow-up should be established and

documented on the Case Transfer Plan before the household is transferred.

**3. The Case Worker/Case Manager should always inform necessary government officials or community leaders of the transfer.**



**CM STEP 7 – STANDARD OPERATING PROCEDURES FOR MANAGING ATTRITION**

**WHAT:**

Attrition is the premature termination of support to a child and/or household due to circumstances beyond the control of the programme. Attrition occurs when the child and/or household requests to no longer participate in the given OVC programme, the programme is unable to locate the child and/or household, or the child dies.

**TOOL:**



- Completed CM Step 4 **Tool 1:** Case Planning with Caregivers, Children 8-11 years and Adolescents 12-17 years (OVCMIS FORM 012A)
- Completed CM Step 2 **Tool 1:** Household Vulnerability Assessment Tool (HVAT) (OVCMIS FORM 007A)
- Completed CM Step 2 **Tool 2:** Adolescent Vulnerability Assessment Tool (AVAT) (OVCMIS FORM 007B) for Adolescents Aged 12–17 years

**WHO FACILITATES:**

The Case Worker facilitates in consultation with the PSWO, CDO or Case Manager.

**HOW:**

**Together with the PSWO/CDO / Case Manager, the Case Worker should:**

1. In the case of refusal to continue in the OVC programme, meet with members of the household to inquire as to why they are refusing and should try to reach an agreement to continue services. If no agreement can be made, the Case Worker and PSWO/CDO/Case Worker/Case Manager should close the case, documenting the reason for attrition on the Case Plan form and requesting that the head of the household sign the form to signify his/her consent to withdraw.
2. In the case of inability to locate a child or household, consult with neighbours, family, and friends for a predetermined amount of time (at least two months is recommended) to try to locate the family. The Case Worker should make multiple attempts to locate the household and should document these attempts on the case plan within the “date of next visit” section. The Case Worker and Case Worker/Case Manager should then close the case.

In the case of child death, obtain a copy of the death certificate from a governmental or nongovernmental health facility, or if there is no death certificate, confirm the death through multiple sources, including neighbours, family, and friends. The Case Worker and Case Worker/Case Manager with the PSWO/CDO should then connect the household with support services such as grief counselling, if available in the community, and should encourage the caregivers to obtain a death certificate if available. The Case Worker may also choose to continue to meet with the family for a few weeks to provide additional psychosocial support. If there are no other children in the family, after a few weeks, the Case Worker and Case Worker/Case Manager should close the case.



## CM STEP 7 - STANDARD OPERATING PROCEDURES FOR CASE CLOSURE

### WHAT:

Actions for case closure as a result of case plan achievement should begin when all members of a household have achieved both the goals of the OVC programme, as outlined in the Uganda Case Plan Achievement Benchmarks/ Indicators for OVC Programming, and the goals identified by the family. Case closure or closure of a case file is an administrative process that occurs when a child and household are no longer receiving CM or OVC programming support. Case closure occurs after case plan achievement, transfer, or attrition.

### TOOLS:



• CM Step 7    **Tool 2:** Case Closure Checklist

(OVCMIS FORM 016)

### WHO FACILITATES:

The PSWO, CDO or Case Manager and the Case Worker facilitate.

### HOW:

#### Together, the PSWO/CDO/Case Manager and the Case Worker should:

1. Review the family folder containing the results of the final Graduation Checklist and other documents, including the household members' completed Household Vulnerability Assessment Tool (or the AVAT Vulnerability Assessment Tool for Adolescents Aged 12–17, in the case of adolescents) and Case Plans for Household, Child or Adolescent.
2. Discuss input from other service providers about the household's readiness to graduate.
3. Confirm the decision to graduate the household.
4. Discuss how to inform all actors at the community level of the case plan achievement/graduation of the household. These actors may include social welfare officers, health care professionals, teachers, Police, Court and others.
5. Identify and formally introduce the graduating family to a family that graduated within the previous year to provide mentorship and a positive example to follow. This mentorship is intended to ease the household's postgraduation transition.
6. Use the Case Closure Checklist to ensure that the household's contact information has been recorded and that the household has information regarding whom to contact in case of emergency.
7. Ensure that Government and IP databases have recorded the case plan achievement/graduation of the household, if applicable.
8. After these steps have been completed, the Case Worker/Case Manager, probation / CDO should close the case.
9. Secure the closed files in the Government and IP offices in a locked cabinet.
10. Send a list of households that "graduated" (i.e., successfully reached case plan achievement) to relevant government officials every three or six months.
11. Safely dispose of the closed files after the number of years required by law.







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