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PEPFAR
U.S. President's Emergency Plan for AIDS Relief

4Children
Coordinating Comprehensive Care for Children

Standard Operating Procedures

for Case Management

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Cover photo: *Lily Bekele Piper for CRS*

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Note: *Job aids, tools, and references are included in the annexes in the order in which they are referenced in the text.*

List of Acronyms

4Children	Coordinating Comprehensive Care for Children Project
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CRS	Catholic Relief Services
CSO	Civil Society Organization
DRC	Democratic Republic of the Congo
GBV	Gender-based Violence
HIV	Human Immunodeficiency Virus
MOU	Memorandum of Understanding
OVC	Orphans and Vulnerable Children
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
SILC	Savings and Internal Leading Communities
SIMS	Site Improvement Monitoring System
SOP	Standard Operating Procedure
TOR	Terms of Reference
TWG	Technical Working Group
USAID	United States Agency for International Development
VSLA	Village Savings and Loan Association

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Glossary

ATTRITION: Attrition within the context of OVC programming is understood as the premature termination of support to a child and/or household due to circumstances beyond the control of the program. Attrition occurs when there is a request from the child and/or household to no longer participate in the given OVC program, the program is unable to locate the child and/or household, or the child dies.[1]

CASE CONFERENCE: A case conference is a formal, planned, and typically multidisciplinary meeting involving service providers from a variety of fields involved in the care of a vulnerable child and/or household. The aim is to review service options across sectors and agencies and to make formal decisions with the best interest of the child/household in mind.[2]

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-centered manner to achieve a specific goal (e.g., child protection and well-being).[3]

CASE MANAGER: An individual working within civil society organizations or government structures who is responsible for managing data flow and providing technical support to and oversight of caseworkers.

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

CASE PLAN ACHIEVEMENT: The point at which children and their caregivers have achieved both the goals of their case plan and the goals of the program, as outlined in the given program's graduation benchmarks, is known as case plan achievement. This step is often also referred to as Graduation.

CASEWORKER: An individual working at the community level who is responsible for conducting direct case management actions with a child and/or household.

CLIENT: A person who uses or receives a service; a client can be a child or an adult.

RAPPORT: Rapport means a good relationship.[4]

RESILIENCY: The ability to manage adversity and change without jeopardizing future well-being.[5]

TRANSFER: The process of supporting the movement of a child and/or household from active participation in a given program to another source of case management support. Other sources of case management support may include government support, community support or support provided by a program funded by another donor. Transfer can occur for various reasons, including due to the child's age, planned geographic relocation of the household (i.e., outside of the program implementation area) or closure or movement of the program.

TRANSITION TO LOCAL OWNERSHIP: The shift in responsibility for an overall OVC response within a community from donor support to local support and ownership.

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[1] 4Children. (2016). Case Management. Internal document.
[2] Global Protection Cluster Child Protection, European Commission Humanitarian Aid, USAID. (2014). Interagency Guidelines for Case Management & Child Protection. Retrieved from *http://ovcsupport.org/resource/inter-agency-guidelines-for-case-management-child-protection/*
[3] Op. cit.
[4] Hepworth, D. H., Rooney, R. H., Rooney, G. D., Strom-Gottfied, K. & Larsen, J. (2010). Direct Social Work Practice: Theory and Skills. Brooks/Cole Cengage Learning: Belmont, CA
[5] USAID presentation. (2016, July).

Background Information

The overall goal of orphans and vulnerable children (OVC) programming is to build the resiliency of families and children affected by HIV and AIDS so that they can meet their health, economic, education, and social development needs. Per the Lantos-Hyde Act, 10% of PEPFAR funding is to be allocated to children affected by HIV and AIDS.[6]

PEPFAR-funded programs must prioritize interventions for "…children who have lost a parent to HIV and AIDS, who are otherwise directly affected by the disease, or who live in areas of high HIV prevalence and may be vulnerable to the disease or its socio-economic effects."[7] This includes children who are living with HIV, children who have lost a parent to HIV and AIDS, children living with HIV positive caregivers, and at-risk children and adolescents living in a high HIV prevalence area (i.e., adolescent girls, children of key populations, children living outside of family care and those out of school). OVC programs need to reach children that are most vulnerable to HIV infection to mitigate the impact of HIV and prevent new HIV infections.

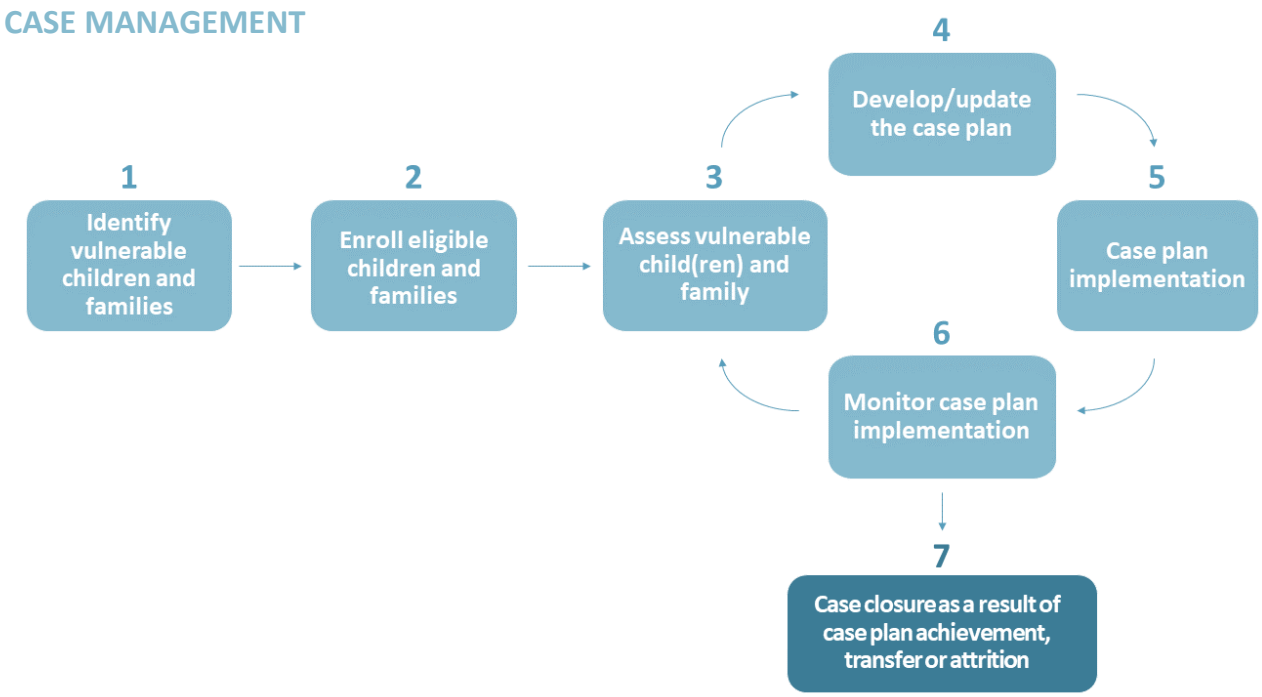

Figure 1. *Case Management Process*

Case management is a process utilized within social services,[8] especially those targeting vulnerable children and families. The goal of case management is for children and households to achieve a state of well-being in which they are stable and secure enough to meet their needs (e.g., financial, protection, social, emotional, health and education) and resilient enough to withstand modest shocks. However, within the context of OVC programming, it is important to recognize that no program can address all needs. As such, the goal for case management will differ slightly depending on the unique resources and parameters of each program. Similarly, children and families do not all have the same needs and therefore the implementation of a unique case plan will vary in intensity, by the number of home visits required by the caseworker and the length and types of interventions.

[6] Civic Impulse (2016). H. R. 5501 –110th Congress: Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV and AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 Retrieved from *https://www.govtrack.us/congress/bills/110/hr5501*

[7] *Ibid.*

[8] Case management started within the field of social work, but has since expanded to be included in the health, education and social protection fields.

Case management includes the processes of and related tools for identifying, assessing, planning, referring and tracking referrals and monitoring the delivery of services in a timely, context-sensitive, individualized and family-centered manner to achieve a specific goal or goals (e.g., child protection and well-being). In many contexts, case management is provided by community-based cadres who come in direct contact with the child and/or family (also referred to as the household). This cadre can be part of government or other statutory bodies (i.e., formal) or be connected to community or faith-based organizations.

Within programming for OVC, case management is the foundation to ensuring that children are healthy, safe, stable and schooled[9] (**Note:** *See Annex 1: Job Aid: Case management for children affected by HIV or living with HIV*). The case management process includes the following seven steps: 1) identify vulnerable children using pre-established targeting or eligibility criteria, 2) enroll eligible children and families, 3) assess a child's and family's needs and strengths, 4) develop a unique case plan, 5) provide direct services or referrals for services, 6) monitor progress toward case plan achievement through assessments (assessment results indicate either the need for revision of the case plan [back to step 4] and continued program support or 7) the child and caregiver[s] are deemed "reached case plan achievement" and are ready to successful exit, because they have met both their own goals and those of the program. At this point their case files can be closed.[10]

ROLES AND RESPONSIBILITIES

At each stage of the case management process there are two key roles: the caseworker and the case manager. A caseworker is typically the front-line worker within an OVC program. This role is typically filled by a cadre of community-based social service workers. Depending on the country context or specific project, this cadre may also be called community health volunteers, community volunteers or para-professional social workers. An illustrative list of responsibilities (i.e., tasks) of the caseworker include:

- manages up to 25 cases at a time depending on the intensity of the assigned cases;
- conducts an assessment for each child and caregiver in an assigned household;
- in consultation with the families, develops case plans;
- depending on the OVC program, provides direct services (e.g., hygiene and parenting advice).
- makes referrals to other service providers;
- monitors progress toward goals either through home visits or check-ins with support groups, e.g., people living with HIV (PLHIV).

A caseworker is a critical component of an OVC program generally, and of the case management process specifically. Therefore, there are some important characteristics to consider when recruiting for this role. These include:

- **Community perception:** a caseworker should be respected by the community.
- **HIV status:** depending on the community, it may be appropriate to aim to recruit caseworkers who are also affected by the disease. This may strengthen the rapport between caseworkers and the children and families with whom they work.
- **Literacy:** caseworkers must be able to read and write in order to complete case management forms.

[9] U.S. President's Emergency Plan for AIDS Relief (PEFPAR) (2015). Technical Considerations for Orphans and Vulnerable Children Programming: *https://www.usaidassist.org/resources/pepfar-ovc-technical-considerations-2015*

[10] 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%20Practice_0.pdf*

When recruiting caseworkers, it is also important to consider gender and age when/where culturally appropriate. For example, female caseworkers might be appropriate for gender-based violence cases. Male caseworkers might be more appropriate to support adolescent boys.

Caseworkers are typically supported and supervised by a case manager. Within OVC programming, a case manager is typically part of the implementing partner staff. However, a case manager can also be part of a government or statutory body in which joint supervision between the OVC program and government occurs. A case manager might carry out the following tasks:

- provide ongoing supervision and support to caseworkers;
- participate in the case management process, including exits via the three pathways;
- ensure proper storage of family folders at the civil society organization (CSO) and/or government office;
- close cases.

(**Note:** *See Annex 2: Job Aid: Supportive Supervision and Annex 3: Job Aid: Caseload Management*.)

The case management process can also involve, to some extent, different people working within other institutions or organizations. Though not directly involved in managing the case, they can play a role in the case management process depending on the individual case plan. One example of this is a community clinic case coordinator. This position might be called something different within different OVC projects or contexts. For example, it could be referred to as a clinic liaison or a facility link officer. However, the roles and responsibilities of this position should be similar across contexts. This position acts as a bridge between community programs implemented by OVC partners and the health facility. It is a critical role in terms of helping to ensure linkages between the health facility OVC programs especially as it relates to HIV testing, treatment and ongoing care, such as attendance at support groups. This position would work closely, in some ways as a triad, with the caseworker and the case manager.[11] These might include police, doctors, nurses, community health workers, magistrates, teachers, social security and labour office workers, religious leaders and coordination mechanisms such as child protection committees.

PATHWAYS OUT OF OVC PROGRAMMING

Most children and families exit OVC programming via three main pathways: graduation or case plan achievement, transfer or attrition. Programs should have standard operating procedures (SOPs) and clear criteria to determine and facilitate the exit of children and families via these pathways.

CASE PLAN ACHIEVEMENT PATHWAY

Also referred to as graduation, case plan achievement in OVC programming can be understood as the defined and measurable stage at which households that are living with or affected by HIV and AIDS have reached a level of resiliency to meet the developmental needs of the children in their care. The concept of case plan achievement relates to the capacity of the household to meet the goals identified in their case plan as well as the given program's graduation benchmarks.

OVC programs are time-bound. Therefore, the implementation of interventions should be based on a rigorous assessment of strengths and vulnerabilities and should result in building the coping skills of families,

[11] For additional information on the roles and responsibilities of a Community Clinic Case Coordinator, please see page 21 of the OVC Technical Working Group document entitled "Consensus Conference Technical Report On The Role Of OOVC Programs Supported By PEPFAR In Extending Access To HIV Testing Services: Rationale, General Considerations And Most Immediate Actions." Retrieved from: *http://ovcsupport.org/wp-content/uploads/2017/03/2016-01-23-Consensus-conference-report-OVC-HTS_Jan-23_FINALwformat.pdf*

while also increasing access to and use of services available for children affected by HIV. Building the resiliency of both the family and children requires focused and evidence-based interventions that have an "end" in mind (i.e., clear and time-bound goals). Once an OVC program has addressed a household's critical vulnerability factors and ensured that children living with or affected by HIV have access to the services they need, then families and children (i.e., households) should be considered for case plan achievement.

The goal of the caseworker is to walk beside the child and family on a pathway toward case plan achievement. (Sylvain Cherkaoui for CRS)

If a child or caregiver has not met the goals outlined in her/his case plan or the goals of the program as outlined in the graduation benchmarks, then the household is not ready to be considered for case plan achievement. A household can reach case plan achievement and exit the program only when it has achieved both sets of goals and can meet the needs of the household without ongoing support from the OVC program. **However, this does not mean that the household does not need other services provided outside of the OVC program.** For example, some cases will require ongoing service and support from other service providers, such as cash transfers or other forms of financial assistance.

A CASE PLAN ACHIEVEMENT APPROACH WITHIN OVC PROGRAMMING

As previously mentioned, the goal of OVC programs is to build HIV-affected families' resiliency to meet the developmental needs of their children, while assuring that children affected by HIV and AIDS have equitable access to health, education and other social services, including protection. OVC programming builds on social work approaches, and is aimed at empowering families and supporting them to identify solutions to address their critical vulnerabilities associated with HIV. OVC programming utilizes a system-strengthening approach and an ecological framework aimed at increasing the capacity of households, communities and governments to work together to establish a sustainable, long-term and country-led response. This response should effectively meet the needs of the most vulnerable households affected by HIV, while simultaneously reducing dependency on development-partner funding, such as PEPFAR.

DEFINITION OF RESILIENCE

Resilience is the ability to manage adversity and change without jeopardizing future well-being.

USAID presentation, July 2016

The purpose of the case plan achievement approach within programs serving OVC living with or affected by HIV and AIDS is to identify households that have received interventions delivered through these programs aimed at building their resiliency, and who are, as the result of these programs, ready and equipped to meet their children's basic and critical developmental needs (**Note:** *See Annex 4: Reference: Strengths and Resilience Based Case Management*). Because of OVC programs, it is hoped that households have the necessary coping skills to meet the lifelong challenges associated with illnesses such as HIV and AIDS with the aim of enhancing their children's overall well-being. Ultimately, the case plan achievement approach is a process of identifying households that can meet their children's priority needs without the external support of a PEPFAR-funded program.

TRANSFER PATHWAY

There are several situations that may result in a family exiting a given OVC program via the transfer pathways instead of the case plan achievement. These include:

- The child ages out of a program;[12]
- The child and/or household plans to relocate;
- The program relocates or closes before recommended interventions have been completed;
- Interventions outlined in the case plan have been completed, but the child and/or household still require services outside of the OVC program.

Transfer within the context of OVC programming is understood as the process of supporting the movement of a child and/or household from active participation in a given OVC program to another source of case management support. Other sources of case management support may include government support, community support or support provided by a program funded by another donor. Transfer occurs at the case level and should not be confused with "transition" to local ownership, the shift of responsibility for an overall OVC response within a community from donor support to local support and ownership.

ATTRITION PATHWAY

The third pathway out of OVC programming is attrition. Attrition within the context of OVC programs is understood as the premature termination of support to a child and/or family due to circumstances beyond the control of the program. These circumstances may include:

- The child and/or household requests to no longer participate in the program;
- The program is unable to locate the child and/or household;
- The child dies.

Attrition should be avoided whenever possible.

[12] For some OVC programs, children may age out or no longer be eligible for services after they reach age 18 and are no longer considered to be children.

Objectives and Audience

The following are objectives for the SOPs:

- To describe how the SOPs and tools included within this global package may be adapted and contextualized to meet the needs of unique project contexts;
- To outline the guiding principles for case management and case plan achievement;
- To articulate definitions for concepts associated with case management;
- To define the roles and responsibilities of each actor involved in the different steps of the case management process;
- To establish minimum standards and quality of service provision to OVC and their families;
- To explain the different steps or actions involved in each part of the case management process.

The aim of this document is to support the social service workers responsible for implementing a case management process within OVC programming. It aims to articulate the main principles and concepts of case management. It includes foundational definitions, SOPs, tools and job aids to help facilitate a standardized approach to case management that is strengths-based, inclusive and integrates a case plan achievement approach. This package is not meant to be prescriptive, but rather to serve as a guide to help inform or reflect upon local and contextualized approaches while maintaining the core concepts, principles and steps contained within the case management process.

USE WITH OTHER TOOLS

The SOPs, guidance, and tools contained in this package are intended to be used alongside other tools developed and used within PEPFAR OVC programs. Several of these tools are referenced in this package, for example the HIV Risk Assessment (Annex 17) and the Graduation Benchmarks Assessment Tool (Annex 24). It is anticipated that these and other tools will continue to be adapted, and the most recent approved version of such tools will be used in tandem with this package. Terminology may vary from one tool to another. For example, outside of this package, case plan achievement may be referred to as graduation, although this is simply using a different term to refer to a shared end goal of all OVC programs. In particular, the Global Graduation Benchmarks for OVC programs were finalized by MEASURE Evaluation, but greatly informed by 4Children through the development of this package and the initial set of Case Plan Achievement Benchmarks in 4Children projects in countries such as Nigeria and Kenya. Following a process of adaptation and finalization by MEASURE, they have been renamed Graduation Benchmarks, and are now required globally across PEPFAR OVC projects. Similar evolution of tools is anticipated, and it is our hope that this package will continue to serve as a foundation for the process of case plan achievement, through which families are supported to meet the developmental needs of their children, and to do so eventually without the formal support of an OVC project.

Note on Contextualization

The SOPs and tools for case management included in this global package are intended to guide program managers, supervisors, case managers and caseworkers in supporting children and families on the path to case plan achievement in OVC programs. Recognizing that OVC programs exist in different settings and contexts, and within diverse enabling government environments, this package of SOPs and tools is intended for adaptation and use in diverse settings by a wide range of actors and cadres with varied capacity.

The SOPs and tools included within are comprehensive and ***reflect best practice*** to support children and families, especially those living with or affected by HIV and AIDS, toward case plan achievement of an OVC program.

Figure 2. *Components to Consider for Contextualization of the Case Management Package*

The SOPs and tools should be contextualized to appropriately reflect the context in which they are being operationalized, as well as the unique needs of both the client population and those serving them. They should be gender sensitive and culturally appropriate. The process should foster ***local ownership*** of the SOPs, tools, processes and outcomes. This requires engagement and ownership by all the relevant community, civil society and governmental stakeholders from the very beginning and throughout the process (see Figure 2 above).

The approach should ***strengthen local, sub-national and national child protection systems***. It should consider the specific vulnerabilities and risks that children and their families face, and strengthen, not erode, existing community mechanisms supporting children and families. The contextualization process should ***build upon and complement existing case management models***, referral pathways, statutory reporting and responses and national monitoring and reporting mechanisms. The process should also ***build upon existing workforce*** (professional social workers and/or para-professionals such as paid and/or volunteer community caseworkers) and consider existing skills and abilities. Gender and age considerations are also critical when identifying the workforce that can best meet the needs of the children, adolescents and caregivers they are supporting. We strongly suggest that the approach reflect and align with the Global Social Service Workforce Alliance's Guiding Principles for Para Professionals.[13]

[13] Global Social Service Workforce Alliance. (2015) Para Professionals in the Social Service Workforce: Guiding Principles, Functions and Competencies. First Ed. *http://www.socialserviceworkforce.org/resources/para-professionals-social-service-workforce-guiding-principles-functions-and-0*.

Training and ongoing coaching and supportive supervision of the workforce should be planned and considered an integral part of any case management approach. (**Note:** *See Annex 2: Job Aid: Supportive Supervision and Annex 3: Job Aid on Caseload Management.)* Linkages with other cadres of the social service workforce or allied workers,[14] including governmental social and health workers and HIV treatment and care service providers, should be strengthened with clear roles and responsibilities. A feedback mechanism should also be in place to ensure the guidance and tools are adapted and informed from on-the-ground practice.

Program teams leading the contextualization process of this global package should consider the following factors.

PROCESS

» Who needs to be involved and consulted throughout the process and what are their roles?

Key stakeholders are likely to include:

- **Children, adolescents and families**. For example, through peer support groups for children, adolescents and caregivers living with HIV, adolescents' peer groups or other relevant groups;
- **Local community** actors, such as child protection and health committees;
- **Other OVC implementing partners;**
- **Implementing partners of HIV care and treatment services;**
- **National and local organizations providing child protection and social services;**
- **Governmental stakeholders** at local, sub-national and national levels, including:
  - Ministry of Social Welfare and other relevant government child protection actors,
  - Ministry of Health and other relevant government HIV actors,
  - Networks and/or collaboration mechanisms focused on HIV, OVC and child protection;
- **International organizations** already working with the government on case management.

» What process will be followed for the contextualization of the case management package?

Decide who will lead the contextualization and design, and who will participate, provide feedback, and validate.

- Ensure **relevant ministry[ies] identified** above is [are] included in the consultation in a significant manner (either as lead, co-lead or other capacity as deemed most appropriate within the country context).
- Decide on members of the **small technical committee** that will lead the contextualization process. In some countries, a case management technical working group (Uganda) or a case management rapid response group (Nigeria) has been established to shepherd this process through from start to finish. In both cases, groups were chaired by government authorities with the aim of ensuring sustainability and leadership while also being inclusive of a wide range of other actors from civil society and academia. (**Note:** *See Annex 5: Reference: Example of Terms of Reference for a Case Management Technical Working Group.)*
- Decide on members of a **rapid response group**, who will provide input and feedback throughout the process;
- Decide on members of a **larger stakeholder validation group**, who will be updated regularly on progress and provide high level feedback at key points and final validation at the end of the process.

[14] Examples of allied workers may include police, teachers, doctors, nurses, community health workers, magistrates, social security and labor office workers, religious leaders and others.

» What is the time frame to ensure the case management package is contextualized?

Decide on a realistic timeline to contextualize the case management package that:

- Allows adequate time to review existing guidance and tools;
- Contextualizes the global package to the national/local context;
- Allows input from all relevant stakeholders;
- Integrates feedback into a final package;
- Validates the final package. If possible, getting government endorsement for the case management package is highly encouraged.

» What is the review mechanism to ensure the case management package is informed by direct practice and learning?

Ensure there is a clear review mechanism in place to:

- Pilot the SOPs and tools and incorporate learning from the pilot;
- Set up regular reviews at set intervals (six months or a year) to collect feedback from caseworkers, their supervisors and other relevant stakeholders;
- Identify and implement approaches on how beneficiaries and communities can provide feedback. (**Note***: Tracer studies may be used as an approach, as well as consultations with peer support groups or other groups, such as adolescent groups for DREAMS projects)*;
- Update the SOPs and tools to incorporate feedback received.

ASPECTS TO CONSIDER DURING THE CONTEXTUALIZATION PROCESS

» What vulnerabilities and risks do children and families living with or affected by HIV and AIDS face? What current community mechanisms exist to support children and families?

Identify existing community mechanisms and/or practices that already exist to support children and families:

- Identify existing support mechanisms that exist within the family and community. These can include places of faith, schools and other community structures; role of and support from extended families and kin;
- Identify positive cultural practices supporting families and children, as well as cultural practices and social norms that might not support the best interests of the child and family;
- Identify existing community mechanisms that identify and support vulnerable children and their families, such as child protection and health committees, community-based peer support groups, etc.;
- Discuss and identify how the case management approach will build on these practice and community mechanisms.

» What case management, referral and monitoring and reporting systems and processes exist?

Ensure that the process begins with a mapping of existing case management, referral and monitoring systems, processes and guidance, specifically looking at the following:

- Current initiatives around case management for vulnerable children;
- Existing SOPs and tools for case management for vulnerable children, e.g., government, and/or other organizations' guidance and tools (**Note:** *The case management assessment framework available in Annex 6 can be adapted and used to assess these*);
- Existing tools for referrals, within and between the health and social service sectors;
- Existing systems for tracking and reporting referrals;
- Existing pathways for referrals and services provided across providers including service directory[ies];
- Existing monitoring and reporting systems (e.g., Child Protection Information Management System), as well as USAID/PEPFAR reporting systems.

» Which local, sub or national cadres work with vulnerable children, and what are their current competencies and required training?

To ensure that the case management workforce builds and strengthens the existing workforce, these steps are recommended:

- Map existing local, sub-national and national workforce delivering services to vulnerable children and their current competency, including any relevant competency frameworks, occupational standards or job descriptions;
- Discuss and identify how the OVC program's paid and/or volunteer cadre will build on the existing workforce, and in particular, from within the community[ies] in which the program is operating;
- Agree upon required competencies, skills and qualifications;
- Clarify roles and responsibilities for all cadres involved (community workers, supervisors, community-clinic focal point, etc.) and relevant supervisory structures;
- Ensure child safeguarding policies and requirements are in place for all organizations and individuals working with children and families;
- Identify requirements for training for the different cadres involved in the program and ensure that the training covers core skills, knowledge and competencies required for the job;
- Identify existing training curricula to build upon and integrate into the new training curriculum. This could include meeting with and reviewing training curricula from certificate courses, as well as schools of social work;
- Identify an existing training, a new training or a combination of existing and new training that is competency based and includes relevant materials related to the case management process and the necessary skills and knowledge required to successfully implement the process. Training curriculum should also include an ongoing mentoring and supportive supervision plan that takes into account HIV and disability sensitivity and non-stigmatization, child safeguarding, best practices in case management and working with children, as well as discussion of the workforce's own cultural or social norms and attitudes;
- Define clear accountability mechanisms with the relevant government structures.

Guiding Principles of Case Management

Client-centered services that prioritize the best interests of the child are central to the guiding principles of case management. (Sam Phelps for CRS)

The principles of case management are informed by and reflect many of the core values and principles of social work,[15] as well as international and national rights-based legal and policy frameworks. When implementing a case management process within an OVC program, the following principles should guide the practice of all actors engaged in the process and be reflected within all decisions made about a case:

- **Do no harm.** Give thoughtful consideration to how your actions will affect the children and households that you serve.

- **Prioritize the best interests of the child.** Within OVC programming, it is good practice and also reflects international and national rights-based legal and policy frameworks[16] that all decisions and related actions involving the child's welfare should be guided by the best interests of the child. (**Note:** *See Annex 7: Job Aid:* The Best Interests of the Child)

[15] National Association of Social Workers (2008). Code of Ethics.
Retrieved from: *https://www.uaf.edu/socwork/student-information/checklist/(D)-NASW-Code-of-Ethics.pdf*

[16] United Nations (1989). Convention on the Rights of the Child; African Union (1990). African Charter on the Rights and Welfare of the Child.

- **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.[17] All actors involved in the case management process will practice respect for cultural diversity. The approach should be gender sensitive and inclusive.

- **Provide client-centered services.** Caseworkers should actively engage children and caregivers in all aspects of case management and tailor services, via a case plan, to meet their unique needs and goals.[18] Finding age- and gender-appropriate ways for children to actively participate in the process and decisions made that affect their lives is not only good case management practice, but the child's right. Children's participation in the process should be determined based upon their age and evolving capacities. Self-determination should also be promoted whenever possible (i.e., promoting the idea that the client is best placed to make his/her own decisions about what is best). (**Note:** *See Annex 8: Job Aid: Communicating with Children and Caregivers and Discussing Sensitive Topics*)

- **Use a strengths-based perspective.** Instead of focusing on needs and deficits, caseworkers should focus on a client's strengths and abilities. This will build on the resilience and potential for growth inherent within each individual. (**Note:** S*ee Annex 4: Reference: Strengths and Resilience Based Case Management*)[19,20]

- **Be goal oriented.** The goal of case management is case plan achievement. Actions should be directed toward meeting this goal.

- **Foster trust and privacy within the client-caseworker relationship.** The alliance between clients and caseworkers is critical for clients to achieve their goals. Both case managers and caseworkers should be sensitive to issues that may lead to stigma (e.g., HIV status, single mother, child bride) and respect their privileged relationships with clients by keeping all information confidential. (**Note:** *See Annex 10: Job Aid: Informed Consent and Assent*)

- **Collaborate with others.** A caseworker should not work in isolation. Proactive collaboration with other service providers, caseworkers and case managers, as well as members of other disciplines and organizations, is integral to the success of a case management process.[21]

- **Recognize that children and households are a 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. Caseworkers should understand the communities in which they work, and consider how the community as a whole may be leveraged to meet the needs of children and families made vulnerable by HIV and AIDS.

[17] *Ibid.*
[18] National Association of Social Workers (2013). NASoW Standards for Case Management. Retrieved from: *https://www.socialworkers.org/LinkClick.aspx?fileticket=acrzqmEfhlo%3D&portalid=0.*
[19] *Ibid.*
[20] PEPFAR (2012). Guidance for orphans and vulnerable children programming. Retrieved from: *http://www.pepfar.gov/documents/organization/195702.pdf*
[21] National Association of Social Workers (2013). NASoW Standards for Social Work Case Management.

Key Principles of a Case Plan Achievement Approach

Case plan achievement is both the goal of OVC programming and case management. Below are key principles for the concept of case plan achievement.

- **Case plan achievement is a defined measurable stage.** This means that OVC programs have identified measurable **benchmarks** that can be used to inform the development of goals in the case plan, and then later be used to help determine if families are reaching case plan achievement and therefore ready to exit the program. (**Note:** *See Annex 12: Reference: Sample Graduation benchmarks for OVC Programming*).

- **Case plan achievement is defined within the scope of the OVC program.** Not all OVC programs deliver the same type of interventions,[22] thus the graduation benchmarks may need to be adapted to align with and reflect the scope of the specific OVC program and its unique context. Global Minimum Benchmarks for PEPFAR OVC Programs have been defined, and OVC programs and their mission must agree if any additional benchmarks will be added. (**Note:** *See Annex 24: Tool: Graduation Benchmarks Assessment Tool*).

- **Case plan achievement requires time.** Though OVC programs need to actively support the goal of case plan achievement, which is directly associated with building the household's resiliency, it would create more harm than good if households were enrolled in OVC programs less than a year and then reach case plan achievement and exit the program. It takes time to build resiliency and coping mechanisms, specifically resiliency in the context of issues associated with HIV. Additionally, families affected by HIV face a wide range of needs that might appear at different times or affect children in different ways. Thus, OVC programs should assess households' readiness for case plan achievement after at least six months of service provision.

- **Case plan achievement allows for OVC programs to increasingly meet community-level demands of children living with and affected by HIV.** Once families successfully exit the program, other programmatic resources can be used to enroll new children and caregivers who need the services provided by OVC programs.

[22] As OVC programs learn from more than ten years of program implementation, many more programs across countries are developing and implementing evidence-based interventions that are often quite similar. However, some OVC programs focus on very young children, while others focus on adolescents; therefore, there are unique interventions and outcomes for different child populations.

Case Management Process Chart

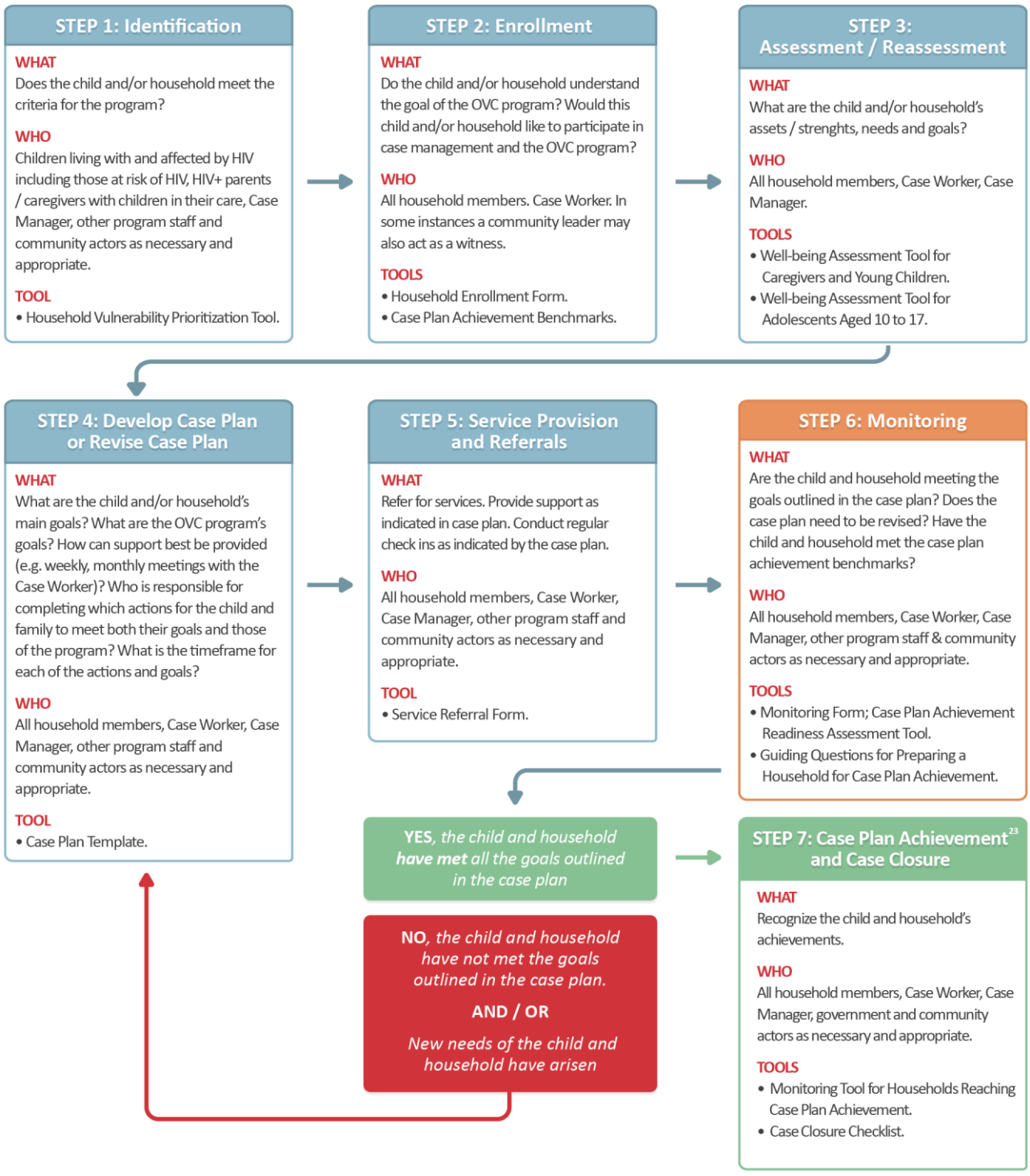

Figure 3. *Case Management Process Chart*

[23] Case plan achievement is the preferred way in which children and families exit an OVC program. However, depending on the circumstances of the family and/or the length of the OVC program, households may be transferred to another source of support through transfer, or exit the program because of attrition. For more information on pathways for exiting OVC programs, please see USAID, PEPFAR & 4Children. (2017). Pathways for Exiting Programs for Children Orphaned or Made Vulnerable by HIV. Retrieved from: *https://www.crs.org/sites/default/files/tools-research/pathways-for-exiting-programs-for-children-orphaned-or-made-vulnerable-by-hiv.pdf*

Standard Operating Procedures

SOP FOR IDENTIFICATION

What: Within OVC programming, identification is the process of identifying children orphaned, affected or made vulnerable by HIV and/or AIDS and other adversities and referring them for services.

Tools:

- Job Aid: Informed Consent and Assent (Annex 10)
- Sample Household Vulnerability Prioritization Tool (Annex 11)

Who facilitates: Case manager, caseworker or other program staff as necessary and appropriate.

Who participates: Children living with or affected by HIV, including children who have lost a parent to HIV and AIDS, children living with HIV+ parents/caregivers, and at-risk children and adolescent girls living in a high HIV prevalence area (i.e., adolescent girls, children of key populations, children living outside of family care, and those out of school); the parents and caregivers of the aforementioned children.

WAYS TO BUILD RAPPORT

- Rapport means a good relationship. In good relationships, people communicate comfortably and understand each other's feelings or ideas. Caseworkers should establish rapport with children and other household members from the beginning of their relationship because it builds trust.
- Greet members of the household warmly, and introduce yourself to each member in a culturally appropriate manner.
- Introduce yourself to the household and ask the head of the household to introduce the other members of the family.
- Get to know the members of the household before beginning to discuss the program. (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).

How: The caseworker, case manager and other program staff should carry out the following steps:

1 | Administer a Household Vulnerability Prioritization Tool to all households within the program's target area. Households may also be referred to the program by health facilities, other service providers and/or community leaders.

2 | Based on the results of the Household Vulnerability Prioritization Tool, identify and prioritize the most vulnerable families for enrollment. If the OVC program has a database, enter the data into the database to identify the most vulnerable households that are eligible to enroll in the given OVC program.

3 | Assign eligible households to caseworkers. If possible, assign caseworker-client pairs per geographic location to reduce the cost and time burden of transportation.

4 | Households not eligible for enrollment should be referred to other programs or services available in the community.

SOP FOR ENROLLMENT

What: Enrollment is the process of registering children and families who are eligible for and want to participate in the OVC program.

Tools:

- Job Aid: Communicating with Children and Caregivers and Discussing Sensitive Topics (Annex 8)
- Job Aid: Explaining Case Management and Case Plan Achievement to Families (Annex 9)
- Job Aid: Informed Consent and Assent (Annex 10)
- Sample Graduation Benchmarks for OVC Programming (Annex 12)
- Household Enrollment Form (Annex 13)
- Job Aid: Data Protection Protocols (Annex 14)

Who facilitates: Caseworker, case manager

Who participates: All members of a household. In some country contexts (i.e., Nigeria) a community leader can act as a witness.

How: The caseworker should carry out the following steps:

1 | Visit the households that they have been assigned by the case manager with the community leader if appropriate within the context. During this first visit, the caseworker should:

   a. Introduce herself/himself to all members of the household, including children (**Note:** *See Job Aid: Communicating with Children and Caregivers and Discussing Sensitive Topics)*;

   b. Introduce the OVC program;

   c. Explain what it means to participate in case management and work toward case plan achievement **(Note:** *See Job Aid: Explaining Case Management and Case Plan Achievement to Families for more information)*;

   d. Share with the members of the household the Graduation Benchmarks for OVC Programming, and ensure that the family fully understands the goals of the OVC program;

   e. Confirm with members of the household that they want to participate in the program;

   f. Build rapport.[24]

2 | If the children and their caregivers want to participate in the program, the caseworker should complete a Household Enrollment Form for the household.[25] If appropriate within the country context, a community leader can witness the members of the household agreeing to participate in the program.

[24] Hepworth, D. H., Rooney, R. H., Rooney, G. D., Strom-Gottfied, K. & Larsen, J. (2010). Direct Social Work Practice: Theory and Skills. Brooks/Cole Cengage Learning: Belmont, CA.

[25] If the children and their caregivers do not want to participate in the program, the caseworker should report this to the case manager.

3 | Establish the date and time for the next visit with the household to conduct the full assessment. This visit should take place within the next week or two weeks as agreed within the program. (**Note:** *If during the enrollment any urgent or life-threatening needs are identified, the caseworker should be prepared to immediately provide a referral to the appropriate organization. Examples of urgent or life-threatening needs may include all forms of violence against children or malnourishment).*

The case manager should carry out the following steps:

1 | Document the enrolled child[ren]'s and household's information in relevant registers according to government or organizational policies.

2 | Establish a family case file that will be stored in a secure location. (**Note:** *See Job Aid 14: Data Protection Protocols for information on how to protect clients' personal information and develop a confidentiality policy).*

3 | Assign the members of the household unique identifier codes according to government or organizational protocols.

SOP FOR ASSESSMENT

What: Assessment is the process during which the specific needs and strengths of a child and/or family are identified. Reassessment will take place if additional needs are identified or on an as-needed basis (i.e., if circumstances within the household change).

Tools:

- Sample Household Vulnerability Prioritization Tool (Annex 11)
- Sample Graduation Benchmarks for OVC Programming (Annex 12)
- Caregiver and Child Well-being Assessment (Annex 15)
- Well-being Assessment for Adolescents Ages 10 to 17 (Annex 16)
- HIV Risk Assessment (Annex 17)

Who facilitates: Caseworker

Who participates: All members of the household

During the assessment, the caseworker identifies the specific needs and strengths of the members of the household. (Jake Lyell for CRS)

How: Before visiting the household, the caseworker should carry out the following:

1 | Use the information from the Household Vulnerability Prioritization Tool to begin filling in the assessment tools. Any information that cannot be completed based on the Household Vulnerability Prioritization Tool should be left blank, and these questions will be asked during the home visit.

2 | During the home visit the caseworker should state that each member of the household will now participate in an assessment to identify their unique needs, assets and strengths.

For the caregiver[s] living in the household:

1 | Explain to the caregiver that you will now ask her/him a series of questions that will enable you to better understand the lives of household members and develop a case plan that best suits their household's unique needs and strengths. Highlight that some questions may be sensitive and if the caregiver prefers not to answer, she/he may refrain from doing so at any time.

2 | Ask the caregiver the questions listed on the Well-being Assessment Tool for Caregivers and Children. (**Note:** *Questions with a circle are connected to one or more graduation benchmarks)*.

3 | Set goals with the caregiver at the end of the Well-being Assessment Tool for Caregivers and Children. Use the Graduation Benchmarks for OVC Programming to guide the goal-setting process. (**Note:** *For more information about goals, see the assessment tool's instruction box. Goals should be achievable within one year because the OVC program will not be able to provide services endlessly)*.

For each boy and girl ages 10 to 17 living in the household:

1 | **Ask the caregiver** if she/he agrees to allow the child to answer a series of questions. If the caregiver agrees, the caseworker and child may choose to move to a location where the child's responses will be confidential. If the caregiver does not agree, the caseworker should conduct the assessment with the caregiver present, making sure that the child/adolescent does not have to answer any question with which he/she is not comfortable. The caseworker should immediately document this refusal by the caregiver and share this information with the case manager.

2 | If the caregiver agrees, explain to the child that you are going to ask him/her a series of questions that will enable you to better understand his/her life and develop a case plan that best suits his/her unique needs and strengths. Highlight that some questions may be sensitive, and the child is not required to answer any question with which he/she is uncomfortable. If an action for service provision is provided, note this action on the case plan form.

3 | **Ask the child** the questions listed on the Well-being Assessment Tool for Adolescents Ages 10 to 17 and tick the responses. (**Note:** *Questions with a circle are connected to one or more graduation benchmarks).*

4 | Set goals with each child at the end of the Well-being Assessment Tool for Adolescents Ages 10 to 17. (**Note:** *For more information about goals, see the assessment tool's instruction box. Goals should be achievable within one year, because the OVC program will not be able to provide services endlessly).*

For all children ages newborn to 17 whose HIV status was indicated as unknown or negative during the previous assessment questions:

1 | Explain to the caregiver that you will now ask her/him a series of questions related to the children's health. Some of the questions may be sensitive, and if the caregiver prefers not to answer, she/he may refrain from doing so at any time.

2 | **Ask the caregiver the questions listed on the HIV Risk Assessment (Annex 17) for each child whose HIV status is unknown or negative,** making an effort not to repeat questions to which the caregiver has already responded or declined to answer.

3 | If the child is determined to be eligible for an HIV test and the caregiver agrees to have the child tested, **the caseworker should provide a referral to testing services.**

After the assessments have been completed, the caseworker should:

1 | Establish the date and time for the next visit with the household. This visit should take place within the next week or two weeks as defined by the program. (**Note:** *If during the assessment any urgent or life-threatening needs are identified, the caseworker should be prepared to immediately provide a referral to the appropriate organization or agency. Examples of urgent or life-threatening needs may include all forms of violence against children or malnourishment).*

2 | Prepare to review the household members' assessment results and goals with the case manager.

The case manager should carry out the following steps:

1 | Based on the assessment results, the case manager should support the caseworker in identifying the needs and strengths of the household members. This conversation is critical because the assessment tools do not provide scores that correlate with specific services to which a family should be referred. This conversation will inform the development of the household's case plan.

SOP FOR DEVELOPING A CASE PLAN

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, caregiver and 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 program. Each member of the household, including all children, should have a case plan that is summarized within a case plan at the family level.

Tools:

- Caregiver and Child Well-being Assessment (Annex 15)
- Well-being Assessment for Adolescents Ages 10 to 17 (Annex 16)
- Case Plan Template (Annex 18)
- Summary of Key Priority Actions to Share with the Household (Annex 19)

Who facilitates: Caseworker, case manager

Who participates: All members of a household

How: The caseworker should carry out the following steps:

1 | The caseworker should review the well-being assessment results with the case manager before developing the case plan, if possible.

2 | After conducting the well-being assessments, a case plan should be developed for the household. (**Note:** *The case plan should be partially filled out (i.e., biodata, etc.) by the caseworker 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 building on the goals identified during the assessment).*

3 | After the Case Plan Template has been completed, the caseworker should complete the Summary of Key Priority Actions to Share with the Household and share it with the caregiver. (**Note**: *It is important that the caseworker share a summary of the information, including the agreed upon goals and the steps necessary to reach those goals, with members of the family, as appropriate. Their active engagement in the process is key to helping them reach their goals).* **Do not include any confidential information the child, adolescent or adult does not want to share with the rest of the family.**

4 | The caseworker should establish the date and time for the next visit.

5 | After the visit with the family, the caseworker should share and review the case plan with case manager.

The case manager should carry out the following steps:

1 | Review the case plan with the caseworker 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 caseworker with any emergency needs identified to be addressed as soon as possible.

3 | Securely store the case plan within the secure and confidential family case file. Depending on the project, if data needs to be entered electronically, that should also be done.

UPDATING CASE PLANS

The case plan should be used to guide the actions of the caseworker and members of the household. A useful way to think about a case plan is as a "road map" that tells us where we are starting, what needs to be done by whom, and by when to get to attain the agreed-upon end result (i.e., case plan achievement).

The caseworker, with support and oversight from the case manager, should use the case plan for ongoing monitoring visits. Depending on the needs of the case, this could vary between once a week for highly vulnerable and complex cases to once a month or once a quarter for other types of cases. At each visit, completed actions should be identified (with a check), and other necessary actions and/or reasons why some actions were not completed should also be noted.

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

SOP FOR SERVICE PROVISION AND REFERRALS

What: Service provision and referrals represent the process for ensuring that children and households receive the services that they require. Depending on the OVC program, services may be provided by the caseworker. This is called "direct service provision." Examples of services that a caseworker may provide include information or trainings on hygiene or parenting. A very important service that all caseworkers provide is psychosocial support. This is the result of routine friendly interactions with members of the household through regular case management meetings. By spending time with children and their families and simply providing support through their presence and attention a caseworker contributes to the household members' overall well-being.[26,27] In addition, case workers provide counseling on important topics, which is also a service (**Note:** *See Annex 22: Job Aid: Key Messages for Caseworkers*).

Some services might be available through other program staff and program areas from the OVC programs, such as positive parenting or savings and loans group. This is also considered direct service provision because the services are provided directly by the project. In addition, because OVC programs do not typically have the resources or expertise to provide all the services that a household may require, a caseworker may refer a family to another organization for some services (e.g., cash assistance, HIV testing and treatment or health 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.[28]

OVC programs should consider referrals at four levels: the national, or implementing partner level; the sub-national, or local implementing partner level; the community level and the case level (Figure 4).

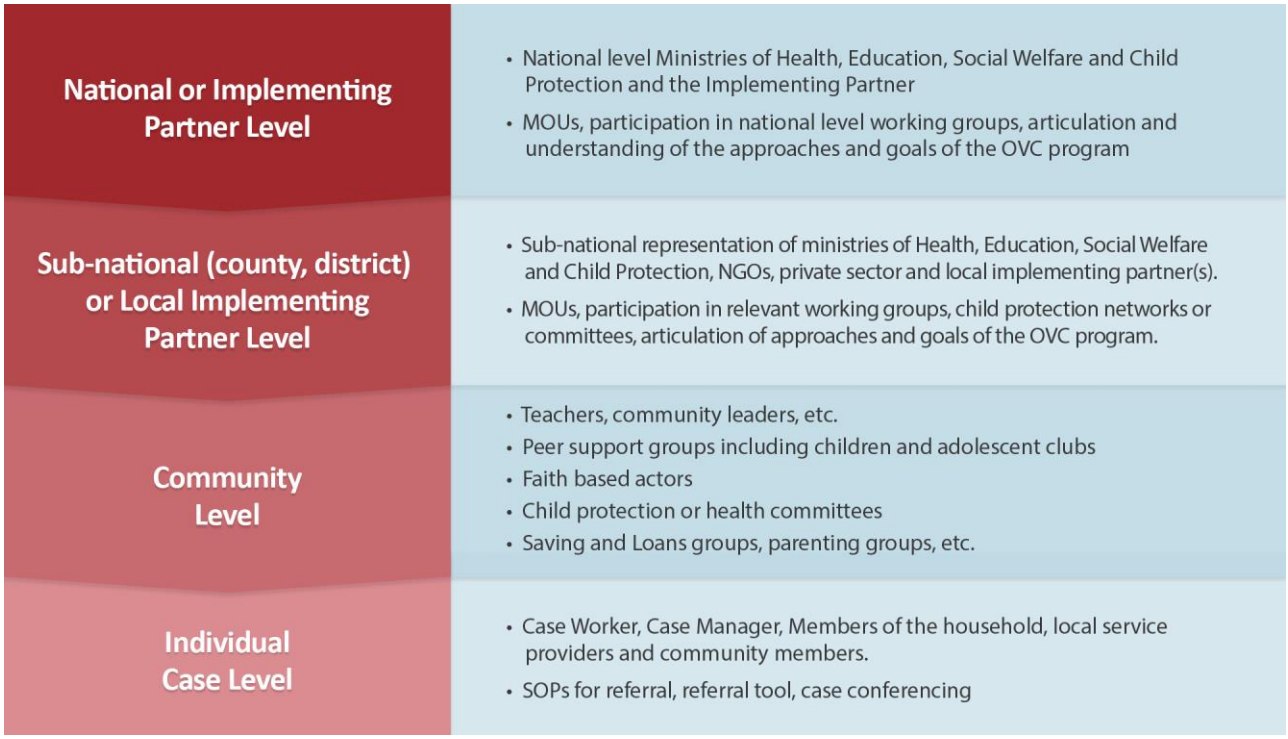

Figure 4. *Levels of Referrals*

[26] Global Protection Cluster Child Protection, European Commission Humanitarian Aid, USAID. (2014). Inter-Agency Guidelines for Case Management & Children Protection.
Retrieved from *http://www.cpcnetwork.org/wp-content/uploads/2014/08/CM_guidelines_ENG_.pdf*

[27] 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*

[28] Save the Children. (2011). Op cit.

At the national or programmatic level, an OVC program must work closely with other key stakeholders whose engagement is critical; these include, for example, the Ministry of Health and health facilities at the national and local levels, Ministry of Social Development or Welfare, child protective services and other relevant social service providers. Stakeholder can be governmental, non-governmental or faith-based agencies/organizations. Conducting a rapid mapping of who these players are at both national and regional or county levels is an important part of program design and implementation. Ensuring that the service providers are aware of the OVC programs, 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 ideally should facilitate referrals at the case and implementing partner levels.

At the sub-national or local implementing partner level (i.e., county, district or sub-national), the implementing partner must also conduct a service mapping, [29] establish and formalize (via an MOU) relationships with key service providers, organize and/or participate in relevant meetings or case conferences and ensure that goals and approaches of the OVC program are clearly articulated to and understood by providers of social services at the sub-national level. One way of facilitating cross-sectoral referrals for OVC at this level is through establishing regular case conferencing meetings engaging relevant service providers and OVC program representatives. An example of how this is done using an established government platform in Kenya is highlighted at right

At the community level, the local implementing partner should be sure to identify relevant service providers such as parenting groups, child and adolescent clubs or support groups, safe spaces, savings and loans groups and faith-based initiatives, as well as organizations that identify and refer child protection concerns/cases such as child protection and health committees, teachers and other school staff and faith-based actors. Ensuring that these services are identified, informed of the OVC program and that an MOU is established are critical first steps.

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 caseworker should identify services needed, discuss these with the members of the household, and then follow the SOPs for service provision and referrals (below) for making a referral. It is very important to remind all of those engaged in the referral process that a referral does not really matter 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). Throughout case management, as part of direct service provision, caseworkers should counsel and educate children living with and/or affected by HIV and their caregivers on topics such as importance of HIV treatment, viral load, positive parenting, nutrition and child protection. Additional information on viral load and key messages that may be shared can be found in Annexes 21 and 22.

Tools:

- Case Plan Template (Annex 18)
- Service Referral Form (Annex 20)
- Job Aid: What is Viral Load and How to Discuss it (Annex 21)
- Job Aid: Key Messages for Caseworkers (Annex 22)

[29] Service mapping provides the foundation for a referral mechanism. In service mapping, information about service (public and private) and other sources of support (such as a youth or mothers' club) in a specific geographic area are collected and shared.

Who facilitates: Caseworker, case manager

Who participates: All members of a household, representatives from receiving service providers

CASE CONFERENCING TO FACILITATE CROSS-SECTORAL REFERRALS: *The experience of 4Children Kenya in using the established government platform of Area Advisory Councils to conduct case conferencing.*

4Children Kenya developed guidance (SOPs) for implementing case conferencing as a means of facilitating increased awareness of the case management process, as well as increasing cross-sectoral referrals. The guidance was contextualized from guidance developed by 4Children South Sudan and can easily be adapted to fit other contexts. Utilizing an established government platform of the Area Advisory Council, which includes representatives from various government bodies, civil society and women and children's groups, the guidance provides clear steps into how to host a case conference, the objectives of the case conference and identified roles and responsibilities of the involved actors. While case conferencing can also occur on an individual case level (see page 41), 4Children Kenya felt that standardizing the practice within an existing platform of multi-sectoral stakeholders would help to inform those stakeholders about the types of cases that are being supported by OVC programming, as well as promote improved referrals and referral completion. The guiding principles highlighted within the Case Conferencing Guidance reflect those of case management and include do no harm; best interest of the child; non-discrimination; child and family centered; strengths based and goal oriented; respect confidentiality; foster collaboration; recognize that children and families are part of a larger community.

How: The caseworker should carry out the following steps:

1 | Based on the needs, strengths and assets identified in the assessment and goals set in the case plan, the caseworker should complete Sections A and B of the Service Referral Form for services that the OVC program cannot provide directly. While completing the forms, the caseworker should engage the child and caregiver[s] to ensure that they are part of the decision-making process and are engaged in following up on the referral.

2 | Record all individual, organization and government services that should be or have been contacted or referred to by the caseworker on the Case Plan Template.

3 | The caseworker, during the home visit, should provide the direct services appropriate to needs identified in the case plan. These will likely include pyschosocial support and counseling on key topics. (**Note:** *See Job Aid 29: Key Messages for Caseworkers*).

4 | The caseworker should ensure that the children and/or caregivers are linked to appropriate services provided directly by the project. These could be household economic strengthening services, parenting capacity strengthening, child, adolescent, or caregiver groups, and others.

Members of the household should carry out the following steps:

1 | The member[s] of the household should then take the Service Referral Form to the receiving service provider and obtain the service. **(Note:** *If the child and/or caregivers do not take the referral form to the receiving service provider, the caseworker should meet with the family to discuss why. In some situations, the caseworker may need to accompany the child and caregivers to the service provider, or work with the family to address challenges related to transport).*

A representative from the service provider should carry out the following steps:

1 | Provide the service outlined in the referral.

2 | Complete Section C of the Service Referral Form and maintain a record of it in the appropriate files, as well as send the client a duplicate copy.

3 | Regularly engage with the caseworker, case manager and/or clinic community case coordinator[30] (if applicable) to ensure that referrals are being completed in a timely and effective manner.

4 | Participate in case conferences on an as-needed basis.

5 | The caseworker should check during the next visit if the service was provided, what the result was and then document it in the case file.

[30] The clinic community case coordinator is typically in a position to support bi-directional referrals between the health facility and the OVC program and other social service providers. This position may also be known as desk officer. See Consensus Conference Technical Report on the Role of OVC Programs Supported by PEPFAR in Extending Access to HIV Testing Services available here: *http://ovcsupport.org/wp-content/uploads/2017/03/2016-01-23-Consensus-conference-report-OVC-HTS_Jan-23_FINALwformat.pdf*

SOP FOR ONGOING MONITORING

What: This SOP describes regular monitoring of the case plan. It 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[ren] or caregiver[s] to determine if and how the case plan is being implemented. Monitoring also allows a caseworker and case manager to track the likelihood that the goals of the case plan and the related actions outlined to reach the goals will be achieved.

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

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 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 the OVC program, caseworkers must meet with the child and caregiver at least quarterly.

For particularly complex cases, case managers may organize what is called a case conference. A case conference typically involves calling together the caseworker, case manager and other service providers in order to share information and coordinate assistance. Case conferences explore multi-sector service options and provide opportunities to discuss the case and make recommendations and associated referrals for children and families. During case conferences, the case plan should be adjusted as necessary.

CLIENT ATTENDANCE AT MEETINGS

The case manager should use his/her professional judgment to decide if it is in clients' best interests to attend the meeting.

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

If the client attends, the case manager needs to ensure that they are introduced and treated with respect.

The case manager should prepare the client for what will happen, sit next to the client, and interrupt the meeting (if necessary) to advocate for the client if anyone is disrespectful.

Even if the client doesn't participate in the case conference, the opinions and input of the child(ren) and family should always be sought prior to the conference meeting to help inform decisions made.

Tools:

- Case Plan Template (Annex 18)
- Summary of Key Priority Actions to Share with the Household (Annex 19)
- Monitoring Form (Annex 23)

Who participates: All members of the household

Who facilitates: Caseworker, case manager

How: The caseworker should carry out the following steps:

1 | Visit the household at the day and time agreed upon in the case plan. During this visit, the caseworker should discuss the case plan with family members using the agreed-upon goals and actions outlined in the case plan to frame the conversation. 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 not, 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).

2 | During subsequent visits to the household either at home or at another location (i.e., at a support group meeting), the caseworker should discuss the household members' progress toward meeting both their goals outlined in the case plan (which also align with the Graduation benchmarks) and update the Summary of Key Priority Action to Share with the Household form accordingly.

3 | If emergency issues arise during the visit (e.g., malnutrition, changes in HIV status or care and treatment plan, child protection concerns), this must be noted in the case plan and appropriate actions must be taken immediately. The caseworker must also alert the case manager and other relevant actors and follow up or make new referrals to other service providers if needed.

4 | Following every visit with the household, the caseworker should record notes that include the date of the next scheduled visit, whether or not the household is on track, any changes in the case plan that need to be made, and notes regarding direct support provided by the caseworker.

SOP FOR MONITORING FOR CASE PLAN ACHIEVEMENT

What: After an agreed-upon period of case plan implementation has occurred, the next step in monitoring is to assess case plan achievement readiness. This is an important part of the monitoring process. Assessing readiness regarding case plan achievement is undertaken using the **Graduation Benchmarks Assessment Tool** (Annex 24).

A family reaches Case Plan Achievement when all household members have met the identified goals in the case plan as well as the overall goals of the OVC program, as defined by the Graduation Benchmarks. The Graduation Benchmarks Assessment Tool provides criteria against which a household can be measured to determine if they are reaching or have reached **the graduation benchmarks.** Graduation benchmarks are objectively verifiable measures that help to track progress toward the achievement of the goals identified by the OVC program as essential for vulnerable children and their caregivers (family/household) to meet prior to exiting the OVC program.

The benchmarks are categorized into four domains, and each domain has between one and seven specific benchmarks. The domains include:

1 | **Healthy**: This domain 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 to enable vulnerable children, especially girls, to stay HIV-free.

2 | **Stable:** This domain includes interventions that reduce economic vulnerabilities and increase resiliency in adolescents and families affected by and vulnerable to HIV.

3 | **Safe:** This domain includes interventions to prevent and mitigate violence, abuse, exploitation and neglect of children and adolescents, including sexual and gender-based violence.

4 | **Schooled:** This domain includes interventions to support children and adolescents affected by and vulnerable to HIV to overcome barriers to accessing education, including enrollment, attendance, retention and progression and/or transition.[31] It also addresses vocational training in the case of some adolescents.

To reach case plan achievement, a household must successfully meet all of the graduation benchmarks and the goals in their case plan.

It is recommended that an OVC program conduct a **Graduation Benchmarks Assessment** after a case plan has been implemented for six months. 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 Graduation Benchmarks Assessment will be conducted. For example, this could be carried out for all cases within the program (i.e., *en masse*) or only for those cases that have been identified as households likely to be reaching case plan achievement via their case plan documentation and ongoing monitoring. This decision should be made based on case file data, financial and human resources available and the needs of the program.

What: Case plan achievement, also sometimes referred to as "graduation," is a concept or an approach that is integrated into the entire case management process, and should be explained to the members of the household from the beginning. **Case plan achievement** is recognized as the point at which all members of a family have achieved both the goals of the OVC project, as outlined in the Graduation benchmarks, and the goals identified by the family and outlined in the case plan.

[31] PEPFAR (2015). Technical Considerations Provided by PEPFAR Technical Working Groups for 2015 COPS and ROPS.

Tools:

- Graduation Benchmarks Assessment (Annex 24)
- Job Aid: Guiding Questions for Preparing a Household for Case Plan Achievement (Annex 25)

Who participates: All members of the household

Who facilitates: Caseworker, case manager

When: There are specific scenarios at which point the Graduation Benchmarks Assessment may take place. The Readiness Assessment can occur six months after the case plan has been implemented, and it can take place again at regular intervals determined by the OVC program.

How:

1 | The caseworker, with support, guidance and oversight from the case manager, should conduct the Graduation Benchmarks Assessment only after informing all members of the household. This explanation should include what case plan achievement is and why it is important; the role of the household in the process, including active engagement by the caregiver[s] and children; explanation of the four domains (healthy, safe, stable and schooled); and the amount of time that the Graduation Benchmarks Assessment will take; how the results will be used; and responses to any questions members of the household might have.

2 | Before going to the household to conduct the Graduation Benchmarks Assessment, the caseworker should work closely with the case manager to review the case file and familiarize herself/himself with the family's strengths and challenges, the case plan and any other relevant information. Some information can be documented using information from the case file and then confirmed with the child[ren] and/or caregiver[s] during the visit.

3 | Upon arriving at the household, the caseworker should introduce the tool, explain the process and answer any questions. The caseworker should also confirm that the members of the household will have at least an hour to participate in the process. Restating that household members' active engagement in the process is critical and that confidentiality will be respected is important. It is also important that the caseworker mentions that she/he will be writing things down as the Graduation Benchmarks Assessment is conducted.

4 | The caseworker will then ask the questions listed on the Graduation Benchmarks Assessment. Be sure to watch the reactions of the caregiver and child to be sure that they fully understand any questions being asked; ask the question again if appropriate.

5 | Once the Graduation Benchmarks Assessment is finished, please review the findings with the caregiver[s] (and child[ren] if age appropriate) and use the Guiding Questions for Preparing a Household for Case Plan Achievement to lead a conversation that could include acknowledging their success. Discuss what case plan achievement means, and develop key actions if it is determined that the household is on the path to case plan achievement, and identify and respond to any issues (i.e., protection, HIV testing or adherence) that need immediate attention.

6 | Thank the members of the household, explain what will happen next, and schedule your next home visit.

SOP FOR CASE CONFERENCING[32]

OVC programs need an established process for case conferencing of service providers to ensure that the full needs of the child and family are met through a coordinated effort. (Ric Francis for CRS)

What: A case conference is a formal, planned and typically multidisciplinary meeting 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 problem from a range of perspectives and identify unique solutions that are tailored to the individual case. This interagency 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. A case conference can take place any time throughout the case management process from assessment and case planning through monitoring to closure.

Tools:

- Confidentiality Agreement Form, found in Job Aid: Data Protection Protocols (Annex 14)
- Case Conference Form (Annex 26)

Who facilitates: Case manager with the caseworker can call a case conference on behalf of a single child, multiple child and/or households.

Who participates: An interagency or multi-sectoral team is assembled to provide input and develop a case plan as a team. Representatives from each organization/group of the multi-sectoral team should attend to ensure that each person is aware of each member's responsibilities for following through on specific actions and/or referrals. Every team member in attendance should sign a Confidentiality Agreement Form, which can be found in Annex 14: Job Aid: Data Protection Protocols.

Before a case manager and caseworker call a case conference, they should familiarize themselves with the case and determine if it is appropriate for the child or caregiver to also attend the conference.

[32] Adapted from: Government of Malawi Child Protection Case Management Framework (2015).

How: The case manager and caseworker should carry out the following:

1 | The case manager and caseworker who feel that a case or multiple cases would benefit from a conference arrange a time and place and invite those who are pertinent to the case[s].

2 | Prior to the conference the case manager and caseworker should review the case file[s].

3 | Based on the information gleaned from the case review, the case manager and caseworker should narrow down the main issues they want to discuss during the meeting. It is often helpful to note these on a flipchart, blackboard or screen to stay focused. It is also important to note that the case file brought to the case conference meeting is subject to all confidentiality and data protection protocols.

4 | Everyone attending should sign the Confidentiality Agreement Form upon arrival, and no confidential information should be shared until all in attendance have signed.

5 | The case manager should convene the case conference, and welcome and introduce all participants.

6 | After participants have exchanged introductions and welcomes, the convener presents the objectives of the case conference and agenda items.

7 | The meeting proceeds with a case-by-case presentation of matters brought before the conference. The aim is to share information and make plans for the case[s] discussed.

8 | The caseworker presents the case for discussion. During the presentation, the caseworker should highlight processes that have already taken place (i.e., identification, full assessment, case plan, referrals and monitoring visits) and the challenging areas where input of case conference participants is required. For cases brought to the conference after case planning, the case manager should highlight the actions outlined in the case plan and how these actions were implemented.

9 | The conversation should be respectful of clients, and if other agencies are involved, as little information as is necessary regarding the points of discussion should be shared, and nothing further.

10 | During discussions, the convener should let participants share experiences in handling similar cases, ensuring that case confidentiality is respected. First-hand examples enrich the discussion and provide opportunities for learning.

11 | After discussions, case conference participants should agree on what actions should be taken, by which players and within what timelines.

12 | The caseworker or case manager should record meeting minutes, decisions made, assignments made and follow-up actions to be taken.

13 | Proceedings of the case conference can be summarized by the caseworker using the Case Conference Form and included within the family's case file. Action steps, persons responsible and a timeline for completing the action steps should be documented on the Case Plan Template.

14 | The minutes summarized in the Case Conference Form should be sent to the attendees for use in follow-up.

15 | A follow-up case conference should be planned to assess progress toward agreed-upon actions.

PATHWAYS OUT OF OVC PROGRAMMING

Most children and households exit OVC programming via three main pathways: case plan achievement, transfer or attrition.

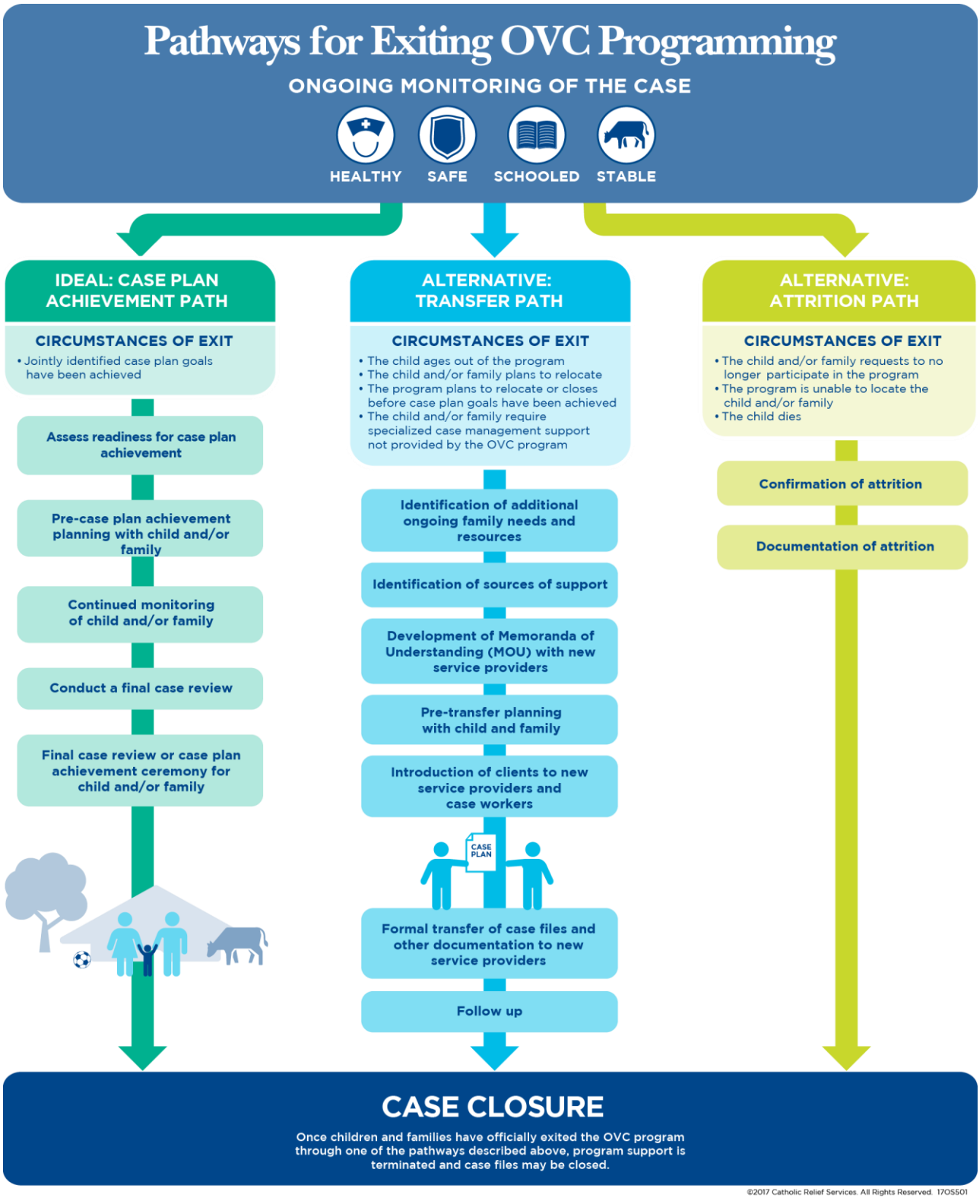

Figure 5. *Pathways for Exiting OVC Programming*

SOP FOR CASE PLAN ACHIEVEMENT

What: Actions as a result of case plan achievement should begin when all members of a household have achieved both the goals of the OVC program, as outlined in the Graduation benchmarks, and the goals identified by the family.

Tools:

- Monitoring Tool for Households Reaching Case Plan Achievement (Annex 27)

Who facilitates: Caseworker, case manager

Who participates: All members of the household

How: The caseworker should carry out the following steps:

1 | Monitor the household for a period of three to six months after all members of the household have achieved goals in the case plan and the Graduation Benchmarks.

2 | During each home visit complete a Monitoring Tool for Households Reaching Case Plan Achievement to ensure that the household has maintained the progress gained while receiving services.

The case manager and caseworker should carry out the following steps together:

1 | Review the family folder containing the results of the final Case Plan Achievement Checklist and other documents, including the household members' completed well-being assessment forms, case plan, and Graduation Benchmark Assessment Tool.

2 | Discuss input from other service providers regarding the household's readiness to exit the program.

3 | Confirm that case plan achievement has been reached, and the household is deemed ready to exit the program.

4 | Discuss how all actors at the community level are to be informed of the exit of this household; these may include social welfare officers, health care professionals, teachers and others.

5 | Identify and formally introduce the successful exiting family to a family that has reached case plan achievement and exited the program within the last year to provide mentorship and a positive example to follow. This is intended to ease the household's post-exit transition.

6 | Following these steps, the case manager should close the case.

SOP FOR TRANSFER

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

Tools:

- Case Transfer Plan (Annex 28)

Who facilitates: Caseworker, case manager

Who participates: All members of the household, other service providers as deemed appropriate

How: The caseworker and case manager should carry out the following steps:

1 | Develop a Case Transfer Plan.

   a. Identify additional ongoing household needs and resources. The caseworker may identify the child's and household's specific needs, strengths and assets by reviewing their assessments and case plan. From this review, the caseworker should compile a list of children and households that require ongoing support and a general description of the type of support required.

   b. Identify sources of support or other support organizations. The caseworker and case manager should utilize existing networks of service providers or those identified through service mappings to identify appropriate service providers to whom the case may be transferred.

   c. The case manager and/or the CSO as an organization should develop an MOU with alternate/new service providers who 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.

   d. Plan the transfer with all members of the household. The caseworker and/or case manager should explain the transfer process to the family, describe the services that will be provided by the new service provider, and describe any final assistance that the current OVC program will provide. The members of the household should also be given the option to accept new services or exit the program without transfer. In this case, the case should be closed.

   e. Conduct final case plan review. The caseworker 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 program.

2 | Implement the Case Transfer Plan.

   a. Introduce the family to the new service provider and review the household members' case plan and family folder with the new caseworker.

b. The OVC program should formally transfer copies of the family folders in a confidential and organized manner. The original copy of the family folder should stay at the transferring organization to retain a record of the service they provided.

c. The case manager should follow up with and support the new service provider to ensure that the child and family 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 in the Case Transfer Plan before the household is transferred.

3 | Inform necessary government officials or community leaders of the transfer.

SOP FOR ATTRITION

What: Attrition is the premature termination of support to a child and/or household due to circumstances beyond the control of the program. Attrition occurs when the child and/or household requests to no longer participate in the given OVC program, the program is unable to locate the child and/or household, or the child dies.[33]

Tools:

- Case Plan Template (Annex 18)

Who facilitates: Caseworker, case manager

How: The case manager and caseworker should carry out the following steps together:

1 | In the case of refusal to continue in the OVC program, the caseworker and/or case manager should meet with members of the household to inquire why, and try to reach an agreement to continue services. If no agreement can be made, the caseworker and case manager should close the case, documenting the reason for attrition on the Case Plan Template, and requesting that the head of the household sign the form to signify her/his consent to withdraw from the program.

2 | In the case of inability to locate a child or household, the caseworker should consult with neighbors, family and friends for a predetermined amount of time to try to locate the family; it is recommended that attempts to locate the child or household should span at least two months. The caseworker should make multiple attempts to locate the household, and each attempt should be documented in the case plan within the "date of next visit" section. If all attempts to locate the child or household fail, the caseworker and case manager should then close the case.

3 | In the case of child death, the caseworker should confirm the death through multiple sources, including neighbors, family and friends. The caseworker and case manager should then connect the household with support services, such as grief counseling, if available in the community and encourage the caregivers to obtain a death certificate if available. The caseworker 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 should be closed.

[33] 4Children (2016). Case Management. Internal document.

SOP FOR CASE CLOSURE

What: Case closure or closure of a case file is an administrative process that occurs when a child and household are no longer receiving case management and OVC programming support. Case closure occurs after case plan achievement, transfer or attrition.

Tools:

- Case Closure Checklist (Annex 29)

Who facilitates: Case manager, caseworker

How: The case manager and caseworker should carry out the following steps together:

1 | 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.

2 | Ensure that CSO's database has recorded the closure of the household.

3 | Close case files and secure the files in the CSO office in a locked cabinet.

4 | Send a list of closed cases to relevant government officials every six months.

5 | Safely dispose of the files after the number of years required by law.

ANNEX 1: Job Aid: Case Management for Children affected by HIV or living with HIV

Case management is essential for HIV prevention and to support children and families living with and affected by HIV.

HIV-sensitive case management can:

- Ensure that children who are in need of protective services (for example, if they have been physically or sexually abused, exploited or neglected) are rapidly referred to HIV prevention and support services, and that their HIV needs, as well as other health and psychosocial needs, are followed up;
- Improve the chances that children and caregivers and families who are at risk of HIV, but are isolated from health services, can – and will – access HIV counseling, testing and treatment and support services;
- Increase and improve linkages between HIV prevention, care and support services and other family-strengthening services.

Having a case management process that is sensitive to and built around HIV and child protection is essential, because there is conclusive evidence that children affected by HIV face increased exposure to abuse, violence and/or neglect, either within the household or in the community. [34]

- Children affected by HIV face increased exposure to abuse and violence or neglect, either within the household or in the community.
- Children who are orphaned due to AIDS, or who live with an HIV-positive caregiver who is sick, are more likely to face physical and emotional abuse, even compared to other orphans. This may be because of the increased economic and stigma-related pressures that the child and family face, or it may be because the child is living with extended family members, who are discriminating. The impacts of grief and trauma may also be factors contributing to the higher risk of physical and/or emotional abuse faced by these children.
- Children who have been sexually abused are at higher risk for sexual exploitation and other HIV risks. It is very important that clinic and community support for sexual abuse link to psychosocial support and HIV prevention.
- Children living with HIV have improved treatment outcomes when their psychosocial needs are met; much of the psychosocial impact relates to HIV stigma and results in neglect or abuse.

The case management process, including standard operating procedures and tools, are designed to address the links between HIV and child protection. This includes looking at risks and vulnerabilities, and also identifying the protective factors that contribute to resilience (**Note:** *See Annex 4: Reference: Strengths and Resilience Based Case Management*). The process also requires that caseworkers and other staff involved in case management have basic knowledge of HIV testing, treatment and care, as well as child protection. This includes having the skills to talk about sensitive issues and knowledge about where to refer for critical services when a protection risk is present or HIV is a concern. Recognizing the links between HIV and child protection also requires strong coordination between OVC programs, government child protection services and health facilities (**Note:** *See Annex 8: Job Aid: Communicating with Children and Caregivers and Discussing Sensitive Topics*).

[34] For more information on this, see World Vision, UNICEF (August 2016). Protection and resilience: A simple checklist for why, where and how, to coordinate HIV and child protection policy and programming. *http://ovcsupport.org/resource/protection-and-resilience-a-simple-checklist-for-why-where-and-how-to-coordinate-hiv-and-child-protection-policy-and-programming/*

ANNEX 2: Job Aid: Supportive Supervision

Through supportive supervision, the caseworker can better manage their workload and respond to challenges. (Georgina Goodwin for CRS)

An important part of successful implementation of a case management process within OVC programming is supportive supervision of those performing the bulk of the case management activities (e.g., caseworkers, community volunteers). As OVC programming integrates a case management approach, supervision of the process and support of the caseworker play a critical role in the overall success of the case management process. The supervisory role is typically a person within the implementing partner organization or government body whose mandate is to provide guidance and support and upon whom ultimate responsibility for the outcomes of the case management process rests. Another significant part of this job is supervising the caseworker.

Supervision is exercised by the supervisor, who is responsible for providing direction and support to the case manager, who then applies in practice theory, knowledge, skills, competency and ethical content.[35] Both the supervisor and the case manager assume responsibility for carrying out their roles in collaboration. Reflective practice and supervision mechanisms are the main ways through which an OVC program can ensure that caseworkers are guided, coached, mentored and supported administratively, technically and in self-care; that caseworkers are accountable and responsible in their work with children and families; and that all work is of the highest quality.

Reflective practice in social work is an analytical approach that examines the practitioner's thoughts, experiences and actions, and seeks to improve skills as a result. Reflective practice can be enhanced through supervision. Reviewing and reflecting upon a caseworker's experiences, helps to focus on supporting the caseworker to be professional, accountable to herself/himself and others and committed to continual improvement and learning. One way of conducting this type of reflective practice is through case conferencing (see below).

[35] Bunkers and Karama on behalf of the Global Social Service Workforce Alliance (2018). Core Concepts and Principles of Effective Case Management: Approaches for the Social Service Workforce.

Supervision mechanisms act as checks and balances; for example, difficult cases may be discussed in individual or group supervision meetings or in reflective all-team meetings, leading to supportive suggestions and group decision-making to improve the quality of services. Supervision also plays a role in ensuring that caseworkers have the skills to deliver quality, competent services in accordance with guidelines and SOPs. Supervision, both individual and group, is an effective way to enhance skills training and provide mentoring related to real case situations.

Supportive supervision is designed to improve self-awareness and increase the caseworker's knowledge base and decision-making abilities. Supportive supervision involves regular meetings between the supervisor and caseworker, and provides opportunities to collaborate on work plans, carry out individual case review, support decision-making, provide support to cope with stress, and identify on-the-job training and professional development opportunities. Supervision may also include group sessions during which groups of caseworkers review cases together and provide peer support. Supervision protects clients, supports practitioners, and ensures that professional standards are adhered to and quality services are delivered by competent workers. Supportive supervision provides guidance and enhances the quality of work of both the supervisor and the supervisee, and, ultimately, for the client.

Some supportive supervision models that may be helpful, specifically in resource-constrained organizations:

1 | **Coaching and mentoring** are supervision models that involve problem-solving techniques for better client case outcomes (coaching), and help the caseworker to feel more competent and motivated (mentoring) to improve performance as a caseworker. In the long run, both processes help the caseworker feel supported, valued and moving toward greater achievements.

2 | **Peer supervision** is different from traditional forms of supervision in which a qualified "expert" manages the process and provides supervisory feedback. In contrast, peer supervision refers to a reciprocal arrangement in which peers work together for mutual benefit, emphasizing self-directed learning within the context of support and sharing.

3 | **Case conferencing** as a tool for supportive supervision is useful for either a particularly difficult case or a successful case. In either situation, the case conference format is used, but only involves caseworkers and the supervisor. It is primarily peer support, and offers an opportunity for caseworkers to present cases after which their peers discuss the successes and challenges, as well as help identify innovative approaches, solutions and/or lessons learned. The supervisor is typically a facilitator of the case conference, and the caseworkers lead the discussion and learn from one another. This type of a case conference forum is a good tool to use when hosting monthly meetings with caseworkers. It is also good practice to present a case in a less formal setting to prepare for occasions when the caseworker will be asked to present in more formal settings, such as during an official case conference with representatives from different sectors, government bodies and NGOs.

Role of Supervisor (i.e, case manager) in Supportive Supervision

In all of the supportive supervision models mentioned above, it is the supervisor's role to:

- Support the caseworker in increasing knowledge and skills;
- Offer guidance, constructive feedback and monitoring;
- Provide direction regarding goals, priorities and next steps in a case, particularly complex cases;

- Identify any cases that need higher level or urgent support, and ensure that necessary actions are taken or elevated to next-level supervisor if necessary;
- Provide guidance on time management strategies for equitable distribution of time allotted to cases;
- Provide assistance with strategies to organize and manage the caseworker's caseload and prioritize the most urgent cases;
- Identify and prevent work overload of the individual caseworker;
- Provide an avenue for caseworkers to establish clear and realistic workload expectations;
- Identify potential stress levels.

In addition, the supervisor herself/himself should receive the same supervision as above, through regular uninterrupted meetings with his/her own supervisor (project manager or project coordinator).

When providing supportive supervision, the case manager or supervisor should take into consideration the following elements:

- Supportive supervision can help reduce a caseworker's stress and anxiety by demonstrating that decisions regarding caseloads are fair and equitable, and that appropriate support is always provided in complex or urgent cases.
- Inadequate information, poorly informed or unexplained decisions, and/or lack of support with complex cases can cause professional anxiety and heighten the risk of burnout.
- Caseworkers should never be left without support to manage a case that is beyond their capacity and training. A case manager must provide support or seek support from a higher level, for complex cases or any case that stretches a caseworker beyond her/his proven capacity and level of training.

Role of Caseworker in Supportive Supervision

The caseworker also plays an important and proactive role to ensure that adequate support is received through the supportive supervision process. The caseworker's role is to:

- Participate in regular supervision meetings with the case manager;
- Participate in case conferencing and other coordination meetings;
- Seek support – during regularly scheduled meetings and when the need arises – for complex cases or any case that is beyond the caseworker's own capacity and level of training;
- Inform the case manager of any urgent/emergency needs that arise in the case;
- Share openly regarding the total work effort required by the current caseload;
- Seek peer support from – and provide peer support to – other caseworkers related to caseload management.

Helping to manage workload is particularly important as a supervisor in terms of ensuring that caseloads are manageable and in helping caseworkers determine which cases require immediate and intensive engagement and which require less attention. This type of "prioritization" is useful in terms of supporting caseworkers to organize their workloads and schedules. Ensuring that these issues are discussed in regular weekly, bi-weekly or monthly meetings is important, and will help to reduce potential burnout as well as a sense of being overwhelmed that is common among caseworkers dealing with emotionally charged and difficult cases.

For example, if a caseworker has 25 cases, it is important for the supervisor to work together with the caseworker to identify which of these cases require intensive case management and which do not require engagement as frequently. A management ratio of high-intensity cases and low-maintenance cases is critical, and is an important part of supervision. If this ratio is unbalanced, e.g., there are 18 high-intensity cases and seven low-maintenance cases, the supervisor should try to find a way to redistribute cases among other caseworkers or provide additional support to the caseworker to ensure that he/she does not become overburdened and unable to attend to all cases in an appropriate and timely manner. Conversely, if in a caseload review, it is determined that the caseworker has 22 low-maintenance cases that require nominal intervention and only three highly intense cases, the supervisor should assess that balance compared to the caseloads of other caseworkers and adjust accordingly (**Note:** *See Annex 3: Job Aid: Caseload Management for further information on supporting balanced workloads*).

ANNEX 3: Job Aid: Caseload Management

Effective caseload management is a critical administrative function of case management and supervision. It involves the equitable distribution of cases across the available workforce according to cases' complexity and workforce experience, capacity and current workload. Effective caseload management requires monitoring caseloads, tracking and balancing workloads, providing supervision tailored to the complexity of cases, and ensuring support and accountability to caseworkers and clients.

Caseload management is critical to ensure that cases receive adequate attention and responses according to needs, including immediate/emergency needs. In addition, caseload management ensures that the workloads of caseworkers, often volunteers, remain equitable and manageable, in order to promote their success and well-being and the success and well-being of the families they serve.

Unbalanced or ineffective caseload management can lead to burnout among caseworkers and case managers, as well as reduced quality of services to clients. Therefore, effective caseload management reflects OVC programs' Do No Harm approach, ensuring that quality and timely support and services are provided to clients, and that the approach doesn't take advantage of the volunteer workforce.[36]

While recognizing that there are many factors that should be considered when determining the "ideal" caseload, practice-informed evidence promotes an average caseload of 15 to 30 cases per caseworker. This is to ensure that there is sufficient time for individualized approaches and home visits, when necessary. Furthermore, as supportive supervision is a critical component of quality social work and case management, it is strongly recommended that a supervisor provide supervision to a maximum of 15 caseworkers.

Caseload Management System

- An effective caseload management system includes registers for tracking the following:
- Each caseworker's current caseload (current number of active cases);
- The date of the last home visit for each case and the next scheduled date (this should reflect prioritization of complex or high-priority/urgent cases for more frequent visits);
- An estimation of the weekly and monthly times required by each caseworker to manage his/her caseload, considering:
    - Number of active cases and phase within the case management process (i.e., assessment, case planning, monitoring, preparation for case plan achievement, etc.);
    - Household size of active cases;
    - Complexity and/or urgent needs of active cases;
    - Experience and capacity of caseworker;
    - Distance required to travel to meet clients, as well as difficulty and/or security of terrain;
    - Other factors, such as caseworkers' health and individual abilities[37] to reach clients;

[36] As part of good practice, many OVC programs benefit from the involvement of caseworkers who are living with HIV or other chronic illnesses and/or who have different abilities. This benefits clients by providing positive role models for living with HIV and/or different abilities and support from someone who can more easily relate to challenges associated with HIV and other adversities. To responsibly partner with this highly valuable workforce,

[37] OVC programs must take into account the physical burden of caseloads, especially traveling long distances, in determining the appropriate size of a caseload. Partnership with and listening to caseworkers who are living with HIV and/or different abilities regarding what they believe is an appropriate workload is important to protect caseworkers' health and well-being and their ability to provide services to vulnerable children and their families.

The total work effort associated with a caseload is affected by all of these factors. All factors should be considered, and there is no "one size fits all" answer regarding the appropriate caseload.

See an example of a case register that can be adapted at the end of this annex.

This system will allow the case manager and project manager/project coordinator to:

- Manage their own workloads, and the overall workloads of those whom they supervise;
- Prepare for each caseworker supervision session;
- Plan appropriately, and equitably distribute new cases;
- Respond in a timely manner to requests for support and assistance from caseworkers;
- Report information to the OVC project about the overall caseload and the bandwidth and capacity of the workforce to manage it.

Practical Steps for Caseload Management

While working on establishing or implementing effective caseload management, an OVC program can consider the following checklist:

DOES THE PROGRAM HAVE A REGISTER TO TRACK:	YES / NO
Each caseworker's current caseload (current number of active cases)?	
The date of the last visit to each case and the next scheduled date (reflecting the prioritization of complex or high-priority/urgent cases for more frequent visits)?	
An estimation of the weekly and monthly times required by each caseworker to manage her/his caseload, considering the factors that affect total work effort?	
DOES THE PROGRAM HAVE MECHANISMS IN PLACE TO:	
Review existing caseloads for each caseworker (for example, regular one-on-one meetings with a case manager to meet and discuss each caseload)?	
Review existing caseloads for each case manager (for example, regular one-on-one meetings with a supervisor to meet and discuss each caseload)?	
Provide additional support for complex cases or urgent/emergency needs (including plans for working with the child protection sector on child protection issues)?	
Allocate new cases across the workforce, taking into account capacity, distance and other factors identified?	
Foster peer support among caseworkers, i.e., meetings to discuss and share challenges encountered?	
Develop and regularly update a summary list that includes cases, status and required follow-up actions with dates of last and next visits to support caseload management and regular review sessions?	

CASE PLAN CASE WORKER MONTHLY REPORT

DISTRICT: _____ AREA/ZONE: _____ DATE: ____ / ____ / ____

Caseworker Volunteer Name: _____ Caseworker Supervisor Name: _____

#	CAREGIVER					Village	Number of children under 18 living in the Household								Case Status	Thematic Service Areas	VISITS				Case Closure			Remarks	Mark with large X if the case is a high priority/ urgent case requiring immediate follow-up.
	Name of Caregiver (or head of household)	Household Unique ID	Date of Birth	Gender			<1 year		1-9		10-14		15-17		1. Assessed 2. Case Plan developed 3. Follow up 4. Closed	Indicate areas in which family requires support (eg. economic, nutrition, HIV / health, education, child protection, basic care)	This month	Next 3 months	Timeframe		Achievement	Transfer	Attrition		
				M	F		M	F	M	F	M	F	M	F					Last	Next					
1																									
2																									
3																									
4																									
5																									
6																									
7																									
8																									
9																									
10																									
11																									
12																									
13																									
14																									
15																									

Total # of visits completed this month ☐

Total # of visits planned for next 3 months ☐

Note: *this form is an example, each program can contextualize or adapt it to fit their needs.*

CASE PLAN CASE WORKER MONTHLY REPORT

DISTRICT: _____ AREA/ZONE: _____ DATE: ____ / ____ / ____

Caseworker Volunteer Name: _____ Caseworker Supervisor Name: _____

#	CAREGIVER					Village	Number of children under 18 living in the Household								Case Status	Thematic Service Areas	VISITS				Case Closure			Remarks	Mark with large X if the case is a high priority/ urgent case requiring immediate follow-up.
	Name of Caregiver (or head of household)	Household Unique ID	Date of Birth	Gender			<1 year		1-9		10-14		15-17		1. Assessed 2. Case Plan developed 3. Follow up 4. Closed	Indicate areas in which family requires support (eg. economic, nutrition, HIV / health, education, child protection, basic care)	This month	Next 3 months	Timeframe		Achievement	Transfer	Attrition		
				M	F		M	F	M	F	M	F	M	F					Last	Next					
16																									
17																									
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Total # of visits completed this month ☐

Total # of visits planned for next 3 months ☐

Note: *this form is an example, each program can contextualize or adapt it to fit their needs.*

ANNEX 4: Reference: Strengths and Resilience Based Case Management

Resilience is the ability to recover from challenges, stresses and shocks and to stay as strong, or become stronger, than before. Resilience focuses on the positive aspects, also called strengths, that help children cope and develop in a positive way. Resilience is a crucial factor in children and adults, especially those who live in difficult circumstances, such as those who are living with HIV and AIDS. Identifying, understanding and building resilience based on those strengths is very important, especially as a caseworker. It is the role of the caseworker to identify these strengths, help the child or adult foster those strengths, and design a case plan to utilize those strengths to work toward the end goals of the case management process, including living positively with HIV.

> *"Children are able to be resilient, that is, to bear and recover from significant suffering, when they are surrounded by people who love and care for them. The sense of belonging and hope that is nurtured in these relationships enables children to cope with hardship, including hunger, illness, discomfort, and other privations of poverty and loss."* [38]

Many internal and external factors can contribute to increased resilience including:[39]

- a stable and positive relationship with a least one caregiver, or in the case of an adult, a good relationship with another trusted adult;
- positive parenting skills, especially effective communication and problem-solving;
- a positive view of yourself and your abilities;
- the ability to develop and successfully follow through with a plan;
- strong social relationships, including participation in a support group, a faith-based practice, a women's group or other positive group environments.[40]

Research shows that children who are more resilient tend to have higher self-esteem and greater belief in themselves, along with a sense of having some control over their lives and the ability to make a difference for themselves and others. Being resilient does not mean that a person does not experience difficulty or distress. Emotional pain and sadness are common when having suffered major painful experiences. The road to resilience often involves considerable emotional distress. However, being able to talk about a painful experience and put together a plan to get through the challenge, as well as having a consistent support network of people with whom you can speak and who care about you, are critical factors that will help a person endure difficult circumstances and perhaps come out even stronger than before.

The case management process can do a lot to build up the resilience of children and their family members by facilitating the participation of children and vulnerable families in the case management process – including helping them to recognize their own strengths and abilities. In addition to identifying problems and providing services, caseworkers should consider and build upon the child's and family's capacity to care for themselves.

[38] Richter, L., Foster, G. and Sherr, L. (2006). Where the heart is: Meeting the psychosocial needs of young children in the context of HIV and AIDS. The Hague, The Netherlands: Bernard van Leer Foundation.
Retrieved from: *https://www.unicef.org/violencestudy/pdf/Where%20the%20Heart%20Is.pdf*
[39] Child Protection Working Group (2014). Inter-Agency Guidelines for Case Management and Child Protection.
[40] American Psychological Association. Retrieved from: *http://www.apa.org/helpcenter/road-resilience.aspx;*

Throughout the case management process, caseworkers should focus on empowering children and their families to recognize, prevent and respond to adversities themselves. Helping families, including children, to participate in decision-making by having a say and knowing their voices are heard is an important part of the recovery process that builds their sense of control over their lives and helps them to develop resilience.

The end goal of the case management process is a child living within a strong, committed and stable family, with a supportive social network, who has education and health care, feels loved, and is self-confident about her/his ability to live a positive life, including overcoming any challenges that might be faced in the future. (Michael Stulman for CRS)

ANNEX 5: Reference: Example of Terms of Reference for a Case Management Technical Working Group

Background

An overall aim of Orphans and Vulnerable Children (OVC) programming is to deliver child-focused, family-centered interventions to prevent violence against children and the spread of HIV, and build the resilience of caregivers and children to overcome adversity. This effort relies on the effective and efficient delivery of a range of integrated and coordinated services to achieve a specific goal, typically referred to as case management.

The Uganda Ministry of Gender, Labour and Social Development (MGLSD) has recently embarked on the planned two-yearly revision of existing case management approaches that support OVC programming in the country, as stated in the OVCMIS guide and other national documents.

The intention is to build upon experiences with the existing case management tools to further strengthen these and develop a harmonized national case management toolkit that will assist partners to achieve their OVC graduation targets, and that will also help the ministry in overseeing OVC initiatives implemented in Uganda to respond to child vulnerability and facilitate their progress toward well-being.

The MGLSD has established a technical working group (TWG), entitled the Case Management TWG (CM TWG),[41] which is tasked with provision of oversight and guidance for the review of existing case management approaches and strengthening case management approaches to enable the elaboration of a harmonized national case management toolkit for the country.

The following describes the agreed-upon terms of reference for this CM TWG.

Definition of Case Management

Core components of case management for OVC programming have been determined according to internationally recognized standards, good practices and global principles guiding social work practice.

In the context of OVC programs, case management is thus defined as the process of identifying, assessing, planning, referring, and tracking referrals, and monitoring the delivery of services in a timely, context-sensitive, individualized and family-centered manner. Case management enables social service workers to coordinate multiple services in order to prevent or minimize their fragmentation and facilitate the clients' increased functioning and well-being.

In OVC programing, the process includes child-focused, family-centered interventions that enable effective and efficient delivery of, or referral to, a range of integrated and coordinated services that help the child and the family move along a pathway toward achievement of a specific goal.

Guiding Principles of Case Management

While case management systems will vary depending on the context, effective case management generally adheres to a few guiding principles, as listed below. These principles serve as relevant and meaningful concepts that clarify or guide practice.

[41] This Case Management TWG was initially called the Case Management Rapid Response Core Group.

Effective case management…

- Promotes collaboration and partnership with the "client unit," generally a child or children and their caregivers;
- Whenever possible, facilitates self-determination and self-care through advocacy, shared problem-solving, decision-making and education;
- Uses a strengths-based approach that identifies and builds on a client's strengths, resources, agency and potential contributions to efforts to improve well-being and protection, rather than a pathology-based approach that focuses on the needs of or problems faced by the client;
- Recognizes that children and caregivers have a range of strengths and vulnerabilities, and therefore, a comprehensive set of services and support are required;
- Views the child both as an individual and as a part of the different ecological "systems" (e.g., family, school, community);
- Focuses on coordination and integration among different sectors (e.g., health, education, child protection and social welfare), linking with community resources, and facilitates the navigation and delivery of multiple services and reducing gaps;
- Practices cultural competence, with awareness and respect for diversity;
- Promotes the use of evidence-based care, as available;
- Promotes client safety;
- Promotes the integration of behavioral change science and principles;
- Pursues professional excellence and maintains competence in practice;
- Uses a goal-oriented approach, promotes quality outcomes, and pursues measurement of those outcomes;
- Supports and maintains compliance with any local, organizational and certification rules and regulations related to case management.

The Case Management Assessment Framework

To enable analysis of case management approaches for OVC programming and inform any required strengthening, an assessment framework was developed.

This case management assessment framework is based on global guidance for case management in social work and child protection, as well as an extensive literature review of current case management materials used by OVC programs in several countries in Africa, including Uganda, Ethiopia, Nigeria, Tanzania and Zambia. In order to ground the framework in practical competence and field experience, the case management assessment framework was also informed by consultations with expert practitioners.

The case management assessment framework is designed to guide an assessment of a case management approach used by the government or non-state practitioners. The framework serves to assess tools, standard operating procedures and training curricula used to deliver coordinated comprehensive services to the most vulnerable children and their families.

It is envisioned that the assessment framework will help organizations answer the question "to what extent does the actual implementation of the practice of case management within a specific target setting incorporate the core components of case management at the system and individual practice levels?"

The assessment framework includes three major components:

1 | ***Tools*** that are used by the case manager – implementing partner staff (IPs or NGOs), a volunteer worker or a government social service worker – during home visits and consultations with the child and family. These tools include forms for steps of the case management process, including *screening, enrollment, assessment, referral, monitoring and reassessment and case closure*. The tools can include NGO-specific forms and/or government forms.

2 | ***Standard operating procedures (SOPs)*** that provide guidance and detailed steps, processes and procedures used at each step of the case management process. It is critical that the caseworker knows, understands and follows the guidance provided in the SOPs; these constitute the "backbone" of how case management is carried out. SOPs thus describe how to use the tools listed above, and should clearly define how to identify, assess, develop a case plan, monitor, refer and move toward case closure. SOPs should also define clear steps to identify when a child is at imminent risk of malnutrition, violence, abuse, neglect and/or exploitation, and immediate action needs to be taken to serve the best interests of the child.

3 | ***Training materials*** to build the skills, knowledge and core competencies of the caseworker responsible for delivering case management.

Tools can be collated from a range of sources, or they can be created by the practitioners themselves. Tools must involve guidance, and, as always, they must be contextualized within the local reality.

Overall Purpose of the Case Management Technical Working Group (CM TWG)

The overall objective of the CM TWG is to develop a harmonized MGLSD Case Management Toolkit including the tools themselves, SOPs to guide their use, and a package of training materials to build capacity for use. The aim is that the harmonized toolkit will guide all implementing partners in the country in delivering coherent and comprehensive OVC programming services through the seven globally recognized steps in case management.[42]

The TWG shall review and validate the results of the case management assessment of approaches used by the United States government (USG) and non-USG-supported partners involved in OVC programming, to inform their harmonization at a national level and the development of a comprehensive toolkit for case management that includes tools, SOPs and a training package. The TWG will be led by the Ministry of Gender, Labour and Social Development within the framework of the Social Development Sector.

Working in close collaboration with the Child Protection Sub-committee established under the Social Development Sector Plan, the CM TWG will coordinate the overall harmonization process and will ensure that the TWG deliverables will feed into the Social Protection Committee that is led by the Director of Social Protection at the MGLSD.

4Children Uganda will provide overall support to the MGLSD to lead and coordinate the activities for the review of existing case management approaches and the harmonization process, and will also provide technical inputs to the CM TWG for the development and validation of the Harmonized National Case Management Toolkit including its tools, SOPs and training materials.

[42] Figure 1. Case Management Process (page 9)

Rationale

Harmonizing case management approaches will help the country strengthen the practice of case management for child welfare and measure case management "model fidelity" – on how closely the services and practices provided to children and their families resemble the adopted well-established and internationally recognized case management standards and procedures.

Membership and leadership of the National CM TWG

The membership of the TWG shall include representations from Department of Youth and Children Affairs at the MGLSD; USG and non-USG supported International and National Non-Government Organizations, including:

- Ministry of Education (VAC TWG)
- Ministry of Health
- Ministry of Internal Affairs (Child Protection and Family Unit)
- Justice Law and Order Sector (Juvenile Justice Sub-committee)
- Kampala City Council Authority
- PEPFAR OVC Inter-Agency Working Group
- USG-supported OVC program partners
- UNICEF
- Save the Children International
- Plan International
- World Vision
- Compassion International
- National Children Authority
- ANPPCAN
- Makerere University Department of Social Work and Social Administration

The multi-sectoral composition of membership of the working group will ensure a holistic and multi-sectoral approach toward harmonization of the CM tools, SOPs and training materials. Members of the TWG should be the focal points representing their organizations' leadership in OVC programing case management and are expected to participate as active members of the TWG.

Responsibilities of CM TWG members

Responsibilities of the CM TWG members will include:

- Reviewing, providing input, and approving processes for assessment IP toolkits and materials.
- Regularly attending TWG meetings and sharing information about CM harmonization activities and any challenges encountered.
- Providing strategic leadership and direction for CM harmonization.
- Reviewing existing case management approaches, tools and related training materials.
- Analyzing and formulating recommendations to inform harmonization.
- Developing a harmonized case management toolkit for Uganda.
- Reviewing draft harmonized MGLSD CM toolkit and training package and ensuring its implementation.

To ensure the functionality of the TWG, its members will:

- Designate a focal point within the TWG to manage communication from and to the group members.
- Establish sub-committees to realize specific tasks and report their accomplishments back to the broader CM TWG; each sub-committee will be comprised of a maximum of ten members.

Leadership

MGLSD shall have the overall responsibility and accountability for the coordination of CM TWG.

The Ministry as the chair will be responsible to:

- Ensure the convening of all meetings, report writing and information sharing with the support from all other members.
- Ensure that regular progress is made by the TWG in terms of assessing existing case management approaches in Uganda and building upon these to achieve by the end of June 2018 the expected deliverable of a National Harmonized Case Management Toolkit with tools, SOPs and training materials.
- Conduct advocacy activities to leverage opportunities and fill the gaps from all other stakeholders involved in OVC programming.
- Ensure close and effective collaboration with members and leadership of the MGLSD's other technical working groups by encouraging co-option and provision of strategic and technical support to members.

The Chair will be supported in its leadership and coordination functions by the secretariat of the CM TWG, 4Children Uganda.

Meetings

The CM TWG will meet as frequently as need arises depending on an agreed-upon roadmap for completion of the case management assessment review, validation and development of a harmonized national case management toolkit by its members.

Reporting

The CM TWG, through its chair, the MGLSD, and with support from its secretariat, 4Children Uganda, will report to the Social Protection Committee that is led by the Director of Social Protection at the MGLSD.

Rules of engagement

All TWG member organizations will abide by the following rules of engagement:

- Member representatives must commit to participating in most meetings (maximum of two successive absences);
- Member organizations must assign an appropriate technically competent representative with sufficient decision-making authority to participate in the CM TWG;
- The assigned representative of member organizations must be one same person throughout all meetings.

ANNEX 6: Reference: Case Management Assessment Framework

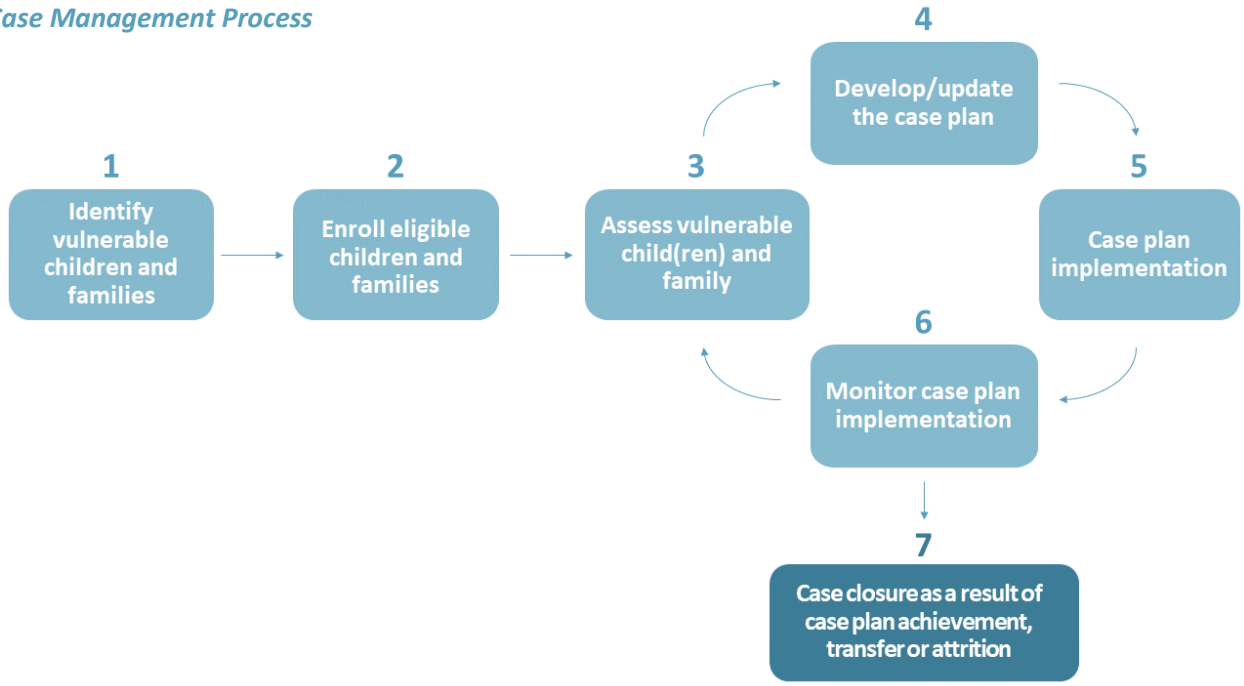
Introduction

An overall aim of OVC programming is to deliver child-focused, family-centered interventions to prevent violence against children and the spread of HIV, and build the resilience of caregivers and children to overcome adversity.

These efforts rely on the effective and efficient delivery of a range of integrated and coordinated services to achieve a specific goal, typically referred to as *case management*. In the context of OVC programs, 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.

The steps of the case management process are illustrated in figure below.

Case Management Process



This case management framework is designed to guide an assessment of a case management approach that includes tools, standard operating procedures (SOPs) and training curricula to deliver coordinated comprehensive services to the most vulnerable children and their families.[43]

While case management systems will vary depending on the context, effective case management generally adheres to a few guiding principles, as listed below. These principles serve as relevant and meaningful concepts that clarify or guide practice, and ensure that case management systems:

- Promote collaboration and partnership with the "client unit," generally a child or children and their caregivers;
- Facilitate self-determination and self-care through advocacy, shared problem-solving and decision-making and education whenever possible;

[43] Families in this context refers to many different types of families: child-headed households, elder caregiver-headed households or parent-headed households.

- Use a strengths-based approach, which identifies and builds on a client's strengths, resources, agency and potential contributions to efforts to improve well-being and protection, rather than a pathology-based approach, which focuses on the needs of or problems faced by the client;
- Recognize that children and caregivers possess a range of strengths and vulnerabilities, and therefore a comprehensive set of services and support are required;
- View the child as both an individual and a part of different ecological "systems" (e.g., family, school, community);
- Focus on coordination and integration among different sectors (e.g., health, education, child protection and social welfare), to link with community resources and facilitate the navigation and delivery of multiple services to reduce gaps;
- Practice cultural competence, with awareness and respect for diversity;
- Promote the use of evidence-based care, as available;
- Promote client safety;
- Promote the integration of behavioral change science and principles;
- Pursue professional excellence and maintain competence in practice;
- Use a goal-oriented approach, promote quality outcomes, and pursue measurement of those outcomes;
- Support and maintain compliance with any local, organizational and certification rules and regulations related to case management.

The case management assessment framework was developed based on an extensive literature review of current case management materials used within OVC programs in several countries in Africa, including Ethiopia, Nigeria, Uganda, Tanzania and Zambia, in addition to global documents on case management in social work and child protection. Furthermore, the case management assessment framework was also informed by consultations with practitioners to ground the framework in practical field experience and expertise.

The case management assessment framework includes **three major components**:

1 | The tools that are used by the case manager, such as implementing partners' (IPs or NGOs) volunteer workforce or a government social worker, during home visits and consultations with the child and family. These tools include forms for steps of the case management process, including screening, enrollment, assessment, referral, monitoring and reassessment and case closure. The tools can include NGO-specific forms and/or government forms.

2 | SOPs include guidance and detailed steps, processes and procedures used at each step of the case management process. Furthermore, SOPs describe how to use the tools listed above. It is critical that the caseworker know, understand and follow the SOPs; these constitute the "backbone" of the case management process. SOPs clearly define how to identify, assess, develop a case plan, monitor, refer and move toward case closure. SOPs also define clear steps when a child is at imminent risk, e.g., malnutrition or violence/abuse neglect or exploitation), and immediate action needs to be taken in the best interests of the child.

3 | Training materials that are aimed at building the skills, knowledge and core competencies of the caseworker responsible for delivering case management. The training materials can include trainings for facilitators/master trainer training and/or caseworker training.

Organization of the Case Management Assessment Framework

The Case Management Assessment Framework includes six parts:

1 | **An overall summary table** capturing the key information of the materials being reviewed. Reviewers are expected to write a few remarks or complete the information requested in the summary table.

2 | **A brief overview** includes overarching questions about the materials reviewed and an analysis of the extent to which they are informed by key principles of social work and recognized good practice of case management. The questions are to be answered using a scale of 1 to 5 (5 – excellent; 4 – good; 3 – somewhat; 2 – below expectations; 1 – not at all). Reviewers are encouraged to add notes to help them rank their answers using the scale.

3 | **A specific assessment for the tools** included in the case management approach being reviewed. The assessment is organized around each step of the case management process. The statements are to be rated using a scale of 1 to 5 (5 – excellent; 4 – good; 3 – somewhat; 2 – below expectations; 1 – not at all). Reviewers are encouraged to add notes to help them rank their answers using the scale.

4 | **A specific assessment for the SOPs** included in the case management approach being reviewed. The assessment is organized around each step of the case management process. The statements are to be rated using a scale 1-5 (5 – excellent; 4 – good; 3 – somewhat; 2 – below expectations; 1 – not at all). Reviewers are encouraged to add notes to help them rank their answers using the scale.

5 | **A brief assessment of the training approaches and materials** included in the case management approach being reviewed. Though questions require a yes/no answer, reviewers are encouraged to add written details whenever possible.

6 | **A summary** of the strengths of the case management approach.

I. CASE MANAGEMENT PACKAGE: ASSESSMENT FRAMEWORK

TITLE OF THE PROJECT:
Name of organization using the case management approach:
Point of contact:
Contact information:
Brief description of the components of the case management approach that will be reviewed, i.e., case management tool[s], standard operating procedures (SOPs), training and/or other documents that are part of the case management approach. Please include details if there is more than one tool or SOP per each step of the case management process.

Geographic areas where the case management approach is used.
Integration of or reflection of key government national policies (e.g., OVC Quality Standards, National Child Policy) into the case management approach.
Clear connections between case management individual tool and SOPs (e.g., the case management tool[s] and related SOPs that support each other, training materials that provide support during implementation).
Clear linkages with or references to other tools/systems capturing efforts to build a family's resiliency (e.g., there are clear pathways between the case management approach and other tools measuring interventions to build family's resiliency, such as the Household Economic Vulnerability Assessment).
Training approach is clearly linked to the case management tools and SOPs (training will be evaluated separately).

II. BRIEF OVERVIEW OF THE CASE MANAGEMENT PACKAGE AND APPROACH

GENERAL INFORMATION

Please assess each statement and rate its accuracy using a scale of 1 to 5
(5 = excellent; 4 = good; 3 = somewhat; 2 = below expectations; 1 = not at all).

1 | The goals and objectives of the case management approach are clearly articulated.

2 | The case management approach is grounded in social work theory and principles (as described above).

3 | The case management approach clearly explains and defines the different steps or components of the case management process.

4 | The concept of case plan achievement (aka graduation) is well integrated in the case management approach, including a clear definition and relevant indicators and benchmarks.

5 | Each step of the case management process (see Figure 1) has a tool[s] or form[s].

a. Identification
b. Enrollment
c. Assessment
d. Case plan development/updating
e. Implementation (referral or direct service delivery)
f. Ongoing monitoring of case plan
g. Case closure

If there are forms or tools missing for particular steps, please list below:

---

6 | To support a multi-sectoral approach and referrals, service mapping is integrated into the case management package. Please provide a list of resources and services provided by government or other service providers or agencies (social protection, education, health, protection and legal) that are identified within the case management package.

7 | The case management tools and SOPs are user-friendly, e.g., the tools are relatively easy for the case manager to fill out and do not require a significant amount of time.

8 | The case management approach includes tools for an individual child as well as a household-based tool to assess a child's strengths and needs within a caregiver/family context.

CASE MANAGEMENT APPROACH INTEGRATES SOCIAL WORK PRINCIPLES

Please rate the accuracy of each statement according to the following scale of 1 to 5:
5 = excellent; 4 = good; 3 = somewhat; 2 = below expectations; 1 = not at all

1 | The core or foundational social work principles are clearly integrated in the following case management approaches:

- Focus on the individual child while understanding the caregiver/family context.
- Do no harm.
- Keep the best interests of the child at the center of all decisions.
- Provide opportunities for the child to be actively engaged in meaningful participation in decisions that affect their lives according to the age and evolving capacities.[44]
- Respect confidentiality.
- Build trust of both the child and the family, and between the child and his/her family.
- View the child as both an individual and also as part of the different ecological "systems" (e.g., family, school, community).
- Identify and build upon the strengths of the child and the household (strengths-based).
- Identify clear steps to reach goals (goal-oriented).
- Include referral tools in case of emergency when a child is at imminent risk (e.g., malnutrition or violence, abuse, neglect or exploitation).
- Define clear procedures – standard operating procedures (SOPs) – if the child is at imminent risk (e.g., malnutrition or violence, abuse, neglect or exploitation).
- Informed by and grounded in international and national child rights-based legal and policy instruments.
- Foster a team approach (a caseworker needs to reach out to other service providers).

[44] *https://www.unicef.org/crc/files/Participation.pdf*

2 | The case management approach includes the following:

- Guidance, tools or SOPs to communicate with and engage the child[ren]/adolescents in an age-appropriate manner, depending upon his/her evolving capacities.
- Guidance, tools or SOPs as to communicate with and engage the caregivers in a proactive and culturally sensitive manner that builds a sense of ownership of the process.
- How to positively engage with the caregivers and/or family members in the process. Examples include identification of strengths, resources, needs, goal setting and articulating roles and responsibilities.
- How to communicate with service providers within the community (government or other community organizations).
- How to integrate socio-cultural norms, i.e., norms that shape how we interact with each other, within case management.

3 | The case management approach provides information on:

- Early childhood development (age and developmental stages of young children less than 5 years old).
- Adolescents' specific emotional, social, intellectual and physical needs and ways to engage them in the process.
- Specific vulnerabilities associated with young children and HIV.
- Specific vulnerabilities associated with adolescents (especially girls) and HIV.
- Specific vulnerabilities associated with children whose caregivers are living with HIV.
- Specific vulnerabilities associated with children living with HIV.
- Key child protection issues, including increased understanding of the increased risk of violence, abuse and gender-based violence associated with children affected by HIV.
- Impact of stress, including mental and maternal health, and the need to focus on parent/caregiver well-being.
- How to cope with stress as a caseworker, i.e., self-care.

III. ASSESSMENT OF CASE MANAGEMENT TOOLS

Please rate the accuracy of each statement according to the following scale of 1 to 5:
5 = excellent; 4 = good; 3 = somewhat; 2 = below expectations; 1 = not at all.

1 | The individual case management tools build upon and reflect the case management stages: identifying, enrolling, assessing, developing a case plan, referring and tracking of referrals, monitoring case plan, and defining case closure.

2 | The individual case management tools include recording forms for documentation and monitoring for each stage of case management.

3 | The individual case management tools include existing Government of Kenya tools and references (national document to identify most vulnerable children-criteria; quality standards for OVC programs, etc.).

Assessing case management tools per stages of case management

STAGES OF CASE MANAGEMENT (to evaluate more in-depth than the overall questions above)	CRITICAL AREAS TO ASSESS	SCALE **5** = excellent **4** = good **3** = somewhat **2** = below expectations **1** = not at all	COMMENTS
Identifying	Lists clear criteria for identifying most vulnerable children.		
	Criteria align with government criteria.		
	Includes a tool to record identification results per child.		
Assessing	Tools facilitating identification and recording of child's strengths are included.		
	Tools facilitating identification and recording of child's needs and prioritization of needs (not all needs can be met) are included.		
	Tools facilitating identification of caregiver's / family's strengths and vulnerabilities are included.		
Planning / Case Plan	Standardized case plan format describing which information needs to be included in a case plan – measurable actions, time line and who does what is included. Direct interventions that can be provided by case manager and needed referrals are identified.		
Referring / Tracking Referral	Referral form exist.		
	Cross sectoral referral forms (e.g. health referral, social protection referral, child protection, etc. have been endorsed by the appropriate government ministry.		
	Counter-referral forms to document that services have been provided by the referred service provider are included.		
Monitoring Case Plan	Tools to measure progress toward benchmarks / fulfillment of case plan are clearly listed.		
Case Closure	Case closure tools are defined, including benchmarks and indicators.		
	Transition tools to other programs established if graduation/case plan achievement has not been reached and child is leaving the program.		

IV. ASSESSMENT FOR SOPS

	SOP TO BE ASSESSED	SCALE	COMMENTS
For each case management stage, there should be clear standards operating procedures (SOPs)		**5** = excellent **4** = good **3** = somewhat **2** = below expectations **1** = not at all	
Identifying	Steps on how to engage community to identify and verify identification of most vulnerable children defined.		
	Describes how to communicate/engage with local government to identify most vulnerable children.		
	Clearly defines processes for sharing data from the identification process with the government.		
	Clearly defines the role of local NGOs/CBOs and local government authorities in working together to identify most vulnerable children.		
Enrollment	Clearly explains how to prioritize enrollment in PEPFAR OVC programs established (not all children will be enrolled in OVC programs).		
	Communication processes with family, community, government and other stakeholders about enrollment established.		
	Defines/explains steps to refer vulnerable children not enrolled in PEPFAR OVC programs to other existing initiatives.		
Assessing	Roles and responsibilities of the child, caregiver/ family and case manager in the assessment process clearly defined.		
	Based on clear goals and related activities that are clearly articulated and time bound, and identifies what steps are to be taken by caregivers/child and caseworker to reach goal.		
	Contains clear steps on how to conduct a strengths-based assessment of both the child and caregiver/family.		
	Guidance on how to identify and prioritize needs (specifically in the context of HIV).		
Developing a Case Plan	Steps on how to engage child and family in developing a goal-oriented case plan are clearly defined.		
	Includes an explanation of how to develop goals and measurable and time-bound actions with the caregiver and child[ren]. Clearly articulates the roles and responsibilities of the child and family and caseworker.		

Referring / Tracking Referrals	Includes guidance on mapping services at community level.		
	Referral procedures to service providers explained. (Steps to communicate the referral information with service providers officer listed.)		
	Case conferencing guidelines are clearly established and articulated to resolve challenges or intensify interventions.		
Monitoring of Case Plan	Monitoring processes by the case manager are established and based upon the level of vulnerability of child/family (e.g., how often to engage with child/family to monitor results will depend on the level of vulnerability of the child and family and their resiliency/strengths).		
	Includes guidance on how to engage children and caregiver in tracking their own progress toward identified goals.		
	Includes guidance on what to do in cases where progress is not made and concerns exist.		
	SOP, guidance or tools exist to support reporting of data extracted from case plan to project, USAID and/or government (please include all entities reported to).		
Case Plan Achievement (graduation) / Case Closure	Clear definition of case plan achievement or graduation, including the definitions of domains and related benchmarks established to help determine case plan achievement readiness.		
	Guidance on how to communicate case plan achievement (graduation)/case closure process with family and child.		
	Procedures for case closure exist.		
	Procedures are in place to transfer cases when case plan achievement has not occurred.		

V. ASSESSMENT OF TRAINING APPROACHES

1 | How is the training approach organized; for example, is there a specific master training manual or training of trainers and a participant training manual? Please describe.

2 | Is the training approach based on caseworker/social worker core competencies required to conduct case management effectively and efficiently? If yes, are core competencies listed in the training materials? Please list.

3 | Is the training organized in a manner that reflects the case management process (per case management tool and SOPs), with clear learning objectives and learning self-assessment tools?

4 | Is the training streamlined, i.e., avoids redundancy for greater effectiveness and feasible time delivery?

5 | Is the training approach based on adult-learning principles and methodologies, e.g., uses case studies, role-play, hands-on experiences, using the case management tools and SOPs? How does the training link with the tools and SOPs?

Does the training approach include key overall information for case managers? *Answer yes or no and add comments wherever possible.*

The training approach includes:

- Roles and responsibilities of a case manager (note: pay particular attention to boundary setting, engagement with the client and areas that require supervision, approval and/or oversight).
- How to build a community of practice – working in teams – and offers opportunities for professional growth and well-being (e.g., stress management, peer support).
- Information on services provided by the government.
- Information on how to build/engage in a trusting relationship with child and family.
- Information on age/stages of development for young children less than 5 years old.
- Information on emotional and social needs of adolescents, specifically girls, affected by HIV and AIDS.
- Information on HIV-specific risks and services available.
- Information on HIV-associated risks (risk of violence, stigma, isolation, mental stress, malnutrition) and services available.

Are the materials provided during training easy to understand and accessible to the caseworker for further reference once on the job?

Is there a mentorship strategy/approach to support participants after training is completed?

VI. SUMMARY OF STRENGTHS AND GAPS

BIBLIOGRAPHY FOR CASE MANAGEMENT ASSESSMENT FRAMEWORK

- **Save the Children (2011).** *Case Management within Save the Children Child Protection Programs*.
- **4Children (2016).** *Case Management for Children Orphaned or Made Vulnerable by HIV* (brief).
- **USAID (2014).** *Case Management Toolkit: A User's Guide for Strengthening Case Management Services in Child Welfare* (developed by Center for International Social Work at Rutgers School of Social Work and International Service).
- **Global Protection Cluster, European Commission and USAID (2014).** *Inter-agency Guidelines for Case Management and Child Protection: The Role of Case Management in Child Protection: A Guide for Policy and Programme Managers and Caseworkers*.
- **O'Leary, P. and Squire, J. (2009).** *Case Management: Systems and Accountability: Social Work in Child Protection Projects*. University of Bath, University of Australia and Terre des Hommes.
- **Global Social Service Workforce Alliance.** *Para-Professionals in the Social Service Workforce: Guiding Principles, Functions and Competencies*.
- **American International Health Alliance (draft, October 2015).** Zambia PSW Training Program Curriculum.
- **American International Health Alliance (2012 revision).** Tanzania Para-Social Work Program Curriculum.
- **The Republic of Uganda Ministry of Gender, Labour and Social Development (December 2015).** *Orphans and Other Vulnerable Children Household Vulnerability Prioritization Tool Kit*.
- **PACT/Ethiopia (2013).** Volunteer Basic Training: Integrated Care for Children for Community-based Support, Refresher Training and Capacity Building. PEPFAR funded-Yekokeb Berhan Programme for Highly Vulnerable Children.
- **Pact/Ethiopia (2012).** *Child Support Index and Care Plan Training for Partners and Volunteers: Facilitators' Manual*. PEPFAR funded Yekokeb Berhan Programme for Highly Vulnerable Children.
- **National Association of Social Workers (2013).** *Standards for Social Work Case Management*.

ANNEX 7: Job Aid: The Best Interests of the Child[45]

The principle of "best interests of the child" was set out in the United Nations Convention on the Rights of the Child (UNCRC).[46] It means balancing all the different elements that inform a child's well-being and that enable the child to fulfill his or her rights. Many important national legal documents include this concept and have developed laws and policies around it. The "best interests of the child" principle is one of the foundational principles that inform our case management work. The SOPs, tools and ways in which we develop case plans and work toward case plan achievement are always guided by the best interests of the child.

Every adult should always think about what is best for a child, including within the short term and the long term. It is the responsibility of the caseworker to always apply the "best interests" principle when making assessments. It is also important to consider the rights and legitimate interests of others when considering a child's best interests. This may include both parents/caregivers (who may have different views), other siblings and family members and other people in the community. Considering the child's best interests may mean making one choice among several different options that are all possible and appropriate.

The caseworker should always think about the best interests of the child when conducting the assessment, developing a case plan with the family, and doing home visits. Note that there is one situation within the case management process for which there must always be a documented best interests decision in the case file: this situation exists when the caseworker suspects or identifies violence, abuse, neglect or exploitation in the home or other environment and the child is at risk. Documenting this concern, telling your supervisor immediately, and recommending an action is of the highest importance, especially if the action involves the recommendation **that the child should be removed from his or her home or that an alleged offender should be removed from the home. It is not the role of the caseworker to remove the child or the offender, but to make a recommendation to her/his supervisor and an immediate referral to the authorities.**

KEY AREAS WHEN CONSIDERING A CHILD'S BEST INTERESTS[47]

1 | The child's own freely expressed opinions and wishes (based on the fullest possible information), taking into account the child's maturity and ability to evaluate the possible consequences of each option.

2 | The situation, attitudes, capacities, opinions and wishes of the child's family members (parents, siblings, adult relatives and/or close "others"), and the nature of their emotional relationship with the child.

3 | The level of stability and security provided by the child's day-to-day living environment.

4 | When relevant, the likely effects of separation and the potential for family reintegration.

5 | The child's special developmental needs related to a physical or mental disability, HIV status and impact or other particular characteristics or circumstances.

[45] The background information in this section is drawn from Cantwell, N., Davidson, J., Elsley, S., Milligan, I., Quinn, N. (2012). Moving Forward: Implementing the 'Guidelines for the Alternative Care of Children.' Retrieved from: *https://www.celcis.org/files/4514/5450/2144/Moving-Forward-implementing-the-guidelines-for-alternative-care-for-children.pdf*

[46] Article 3(1) of the CRC: "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration."

[47] Adapted from Cantwell, N., Davidson, J., Elsley, S., Milligan, I., Quinn, N. (2012). Moving Forward: Implementing the 'Guidelines for the Alternative Care of Children.' Retrieved from: *https://www.celcis.org/files/4514/5450/2144/Moving-Forward-implementing-the-guidelines-for-alternative-care-for-children.pdf*

6 | Other issues related to a child's individual or social well-being, for example, the child's ethnic, religious, cultural and/or linguistic background, so that efforts can be made, as much as possible, to ensure continuity in upbringing, maintenance of links with the child's community, and preparation for transition to independent living.

7 | A review of the suitability of each possible care option for meeting the child's needs, in light of all the above considerations.

CHECKLIST[48]

Caseworkers may find this checklist useful before making a final decision in a child's best interests. This is particularly useful in circumstances in which there are child protection concerns and potential removal of the child is being considered.

1 | **Views of the child**

- Have you explored the child's wishes and feelings? Did the child give these views directly?
- Have you made a decision about the weight to be given to the child's views, in light of the child's age and maturity?
- Have you taken into account the child's ability to comprehend and assess the implications of the various options? Have you provided information in a way that is appropriate for the child's age and maturity?

2 | **Safe environment**

- How safe is the household?
- Is the child or the child's caregiver able to access lifesaving health care or contact the appropriate authorities or police, if this is a consideration in the case?

3 | **Family and close family and community relationships**

- What is the capacity of caregivers to care for the child and protect the child from harm?
- What support do the caregivers receive from other family members, community members or institutions?
- What are the potential effects and implications of the various options on the child and family?

4 | **Development and identity needs**

- Do the options take into account specific considerations based on age, sex, ability, ethnicity, religion, cultural and linguistic background and other characteristics of the child?
- Do the options take into account any disability-specific or HIV-specific considerations, such as access to health and social support, support to combat stigma and discrimination?
- Have the child's physical, mental and emotional health considerations been taken into account?
- Have the child's current and future educational needs been considered?
- Have the child's prospects for successful transition to adulthood (employment, marriage, own family) been taken into account?

[48] United Nations High Commission for Refugees (May 2008). UNHCR Guidelines on Determining the Best Interests of the Child: *http://www.unhcr.org/4566b16b2.pdf*

ANNEX 8: Job Aid: Communicating with Children and Caregivers and Discussing Sensitive Topics[49]

An integral part of the case management process is engaging both caregivers and children, and ensuring they feel that they are part of and own the process. It helps to build trust, mutual respect and desire to work together with the caseworker. How the caseworker 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 caseworker 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 such a way that expresses respect and empathy and builds trust.

Building trust through confidentiality, honesty and keeping commitments is key. It is very important for the caseworker to regularly mention to the caregivers and children that all information shared will remain private and confidential. Respecting the confidentiality of the client is central to building trust. It is also critical that the caseworker always tells the truth, communicates clearly what will happen. It is important for the caseworker to help the client to talk through their concerns and in the process, work out options for overcoming them.

HOW TO DEMONSTRATE RESPECT AND CARE AND LISTEN WITH EMPATHY

- The caseworker should focus entirely on the person in front of him/her and dedicate himself/herself exclusively during discussions with the child and caregiver and what is in their best interests. The caseworker should remember that the child and the caregiver are the most important people at this moment. The caseworker should avoid all distractions during the discussion (i.e., phone calls, etc.).
- The caseworker should try to see the world from the child's and caregiver's points of view.
- The caseworker should be sensitive to social and cultural norms in terms of making eye contact, sitting too close or too far, asking certain types of questions, volume of voice, manner of dress, etc.
- The caseworker should listen with concentration and with a sincere desire to understand the child's or caregiver's views. The caseworker should not assume that she/he knows how the child or caregiver feels. The caseworker should respond with respect and demonstrate understanding. This is called "listening with empathy." The caseworker should avoid responding emotionally, and instead try to acknowledge and/or reflect back the child's or caregiver's perceptions and feelings.
- The caseworker should convey understanding, provide information, and promote the child's and caregiver's ownership. The more ownership the child and caregiver feel, the stronger they will be motivated, and their success will increase their self-esteem and sense of competence rather than dependency on the caseworker.

Demonstrating respect and care and listening with empathy helps to build trust. By listening closely to the caregivers and the children, the caseworker is able to build trust and begin to support the client who has often experienced hardship. This will help the caseworker to discuss difficult topics, such as issues of violence and HIV.

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

[49] Adapted from Ministry of Gender, Labor and Social Development, Uganda (2015). A Holistic Approach to Psychosocial Support: A national training manual for caregivers of orphans and other vulnerable children in Uganda.
Department of Social Welfare, Swaziland (2017). The Community Worker Case Management Handbook.
Government of Malawi (2015). Child Protection Case Management Framework.

or lack of attention. The caseworker should ensure that his/her nonverbal communication demonstrates empathy, care and respect. In addition, it is critical for the caseworker to observe and gather information from children's and caregivers' nonverbal communication. These can include eye contact, gestures, facial expressions, body positioning, interpersonal distance and nonverbal sounds such as sighs, etc.

How to Communicate with Children

When communicating with children and adolescents, the child's/adolescent's developmental stage must be taken into account. It is important for the caseworker to understand children and adolescents from their perspectives. For example, it is helpful for caseworker to sit down to be at the same level and height as the child with whom they are speaking, and engage the child 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 together. For example, drawing or pointing to sad or happy faces or pictures might make it easier for young children to communicate. These approaches may also help when communicating with a child who has a learning or speech impairment. In these situations, the caseworker can also reach out to a supervisor 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 caseworker should start the conversation by discussing topics that interest the young person: ask about favorite foods, school subjects, music, future career interests, etc. Some adolescents find it easier to communicate while they are walking together or in a vehicle, as long as others aren't around so that confidentiality can be ensured.

SUGGESTIONS WHEN SPEAKING WITH A CHILD

- When speaking to a child or listening to a child, focus your attention not only on what he/she says, but also on how he/she acts.
- 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, and do not convey judgment 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 child's level.
- Provide adequate time and space, and talk to the child in an appropriate and conducive environment.
- Assure the child that whatever she/he 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's or adolescent's opinions.
- Do not be afraid of silence when the child needs time and space to gather thoughts.
- Encourage the child by nodding or smiling, but not too often to distract.
- Ask open-ended questions.
- Summarize 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.
- Do not rush children. Be patient, go at their pace, and allow them to express their emotions.
- Encourage the child or adolescent to find solutions to her/his problems and identify positive aspects that would help in finding solutions.

SENSITIVE TOPICS AND DISCUSSIONS

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 communication. It is important for the caseworker to observe the child's and adolescent's behavior and overall nonverbal communication.

The caseworker must know how to build trust, demonstrate empathy and understand nonverbal cues when discussing sensitive topics such as HIV and child protection issues with clients. (Sam Phelps for CRS)

Child protection issues

Children and adolescents do not always wish to share their thoughts or feelings, or even share what happens, for fear of negative consequences for themselves or others. For example, an adolescent may feel that he/she was responsible for abuse experienced when out socializing. In such cases, it is important for the caseworker to make it clear that she/he is not being judgmental, and that it is okay for adolescents to go out and have fun with friends.

Children may also be conscious of the consequences of "getting other people into trouble." It is very important for the caseworker to highlight that the 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 with a caseworker who is of the same gender as the abuser. In this situation, the caseworker should notify a supervisor, and together with the supervisor, identify a caseworker with whom the child will be most comfortable.

The caseworker should keep in mind that traumatized children are often in shock and may not be able to engage. Sometimes this can be misunderstood as the child being unwilling – rather than unable – to talk. It is also important for the child to not be re-traumatized by telling the story again. If the caseworker sees that the child is getting very upset, the caseworker should comfort the child and redirect the discussion to another topic or stop the interview in a calm and supportive way.

The caseworker should report all cases of abuses as soon as possible to a supervisor and the implementing organization to ensure the child receives emergency services immediately.

HIV-related issues

When discussing topics related to HIV, it is very important for the caseworker to highlight to the caregiver and the child that if they feel uncomfortable in any way answering any questions, they can say they do not want to respond and the caseworker will stop. It is important to reiterate that all the answers will be private and confidential to reassure the caregiver and the child that none of this information will be shared.

With the child, the caseworker should use clear and developmentally appropriate explanations and discuss these topics with confidence. It is important for the caseworker to talk *with* the child and not *at* the child and let the child tell his/her story. The caseworker should let the child ask questions and then make sure she/he responds to all questions as best and clearly as possible. The caseworker should discuss with the child what and with whom the child feels comfortable sharing sensitive information.

With adolescents, the caseworker should ensure that adolescents are fully informed of their choices, and the caseworker should provide information so the adolescent can make informed choices. The caseworker should enable adolescents to take responsibility for their own health and well-being.

In all situations, the caseworker should reassure the child, adolescent and/or caregiver that the caseworker's role is to provide support to the child and family.

Managing Hostility or Resistance

When discussing difficult topics, the caseworker might encounter hostility or resistance. In these instances, the caseworker should stay calm and neutral. People in a crisis can become emotional, so maintaining calm and stability are very important. This will, in most instances, prevent the situation from escalating, and will provide opportunities for caregivers, children and adolescents to express their emotions.

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

The caseworker should remind caregivers, children and adolescents that she/he is meeting with them to provide help and support with any issues. The caseworker should listen carefully to what is being said, both in terms of content and emotions, and respond in a respectful manner using empathy and listening skills, as well as observing nonverbal behaviors.

If the client continues to be hostile, angry or upset, the caseworker should stop the conversation in a calm, but firm way. As long as no children in the household are in immediate danger, the caseworker should leave the household and contact a supervisor as soon as possible.

ANNEX 9: Job Aid: Key Messages for Case Workers to Share with Children and Caregivers about Case Management

The OVC project is taking on a case management approach that supports and engages children and their families affected by and vulnerable to HIV. **Case management can be understood as a process that includes identifying, assessing, planning and monitoring using specific tools and actions.** We want caregivers and children to feel part of this process and 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 don't want to do this *for* them; we want to do this *with* them**.

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

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

We use the benchmarks and the Graduation Benchmarks Assessment not to judge the household, but to help us know the goals of the OVC program and give some concrete examples of what the family can work toward. These are outcomes or results that enable the household and the OVC program to know what the family has achieved and assess which areas the OVC program and the caseworker can help them improve.

Another way that we plan and monitor how the family is doing in reaching goals and completing actions is through a case plan. The best way to understand a case plan is to compare it to a road map. This helps the caseworker and the family see where they have come from and know where they want to go, including who is responsible for doing what along the way so that the household can reach the final destination.

Comparing case management to a road map helps families to understand that the caseworker is journeying with the family on a pathway toward self-sufficiency. (Georgina Goodwin for CRS)

ANNEX 10: Job Aid: Obtaining Informed Consent and Assent

The case management approach is built on a strengths-based perspective that seeks to empower children and families to reach their identified goals. As such, before members of a household enroll in an OVC program, participate in the case management process, or receive services, caseworkers should first obtain their informed consent and assent. In addition, informed consent and assent are central to respecting the principle of confidentiality that requires all actors to protect information gathered about clients, and ensure it is accessible only with a client's explicit permission

Consent means that a person who has the capacity to independently make choices voluntarily agrees and gives permission for an action to take place.[50] **Informed consent** means that the individual giving permission fully understands the purpose, risks, benefits and limitations of the services that will be provided; the information that will be collected as part of case management and how it will be used and by whom; their right to refuse to participate and/or answer any questions and withdraw consent at any time; and confidentially and its limitations.[51]

To ensure that consent is informed, caseworkers should:

1 | Use clear, understandable, and age-appropriate language to explain case management and case plan achievement;[52]
2 | Provide members of the household with an opportunity to ask questions;[53]
3 | Verify understanding, if needed, by asking the client to use their own words to explain the process or service that will be provided.

Information related to the OVC program, case management and the services that will be provided may be delivered verbally, and then documented, or it may be delivered in written form in the language that is most familiar to the client. In instances where a client cannot give consent for themselves, the caseworker should protect the clients' best interests and seek permission from a trusted third party (such as a family member). Obtaining consent for a child to participate in or receive a service is an example where consent maybe sought from a trusted third party.

While caregivers may give consent for their children, children's views should also be respected and considered when making a decision that affects them.[54] Children demonstrate their agreement for an action to take place by giving **assent**. The age at which children give consent versus assent is country specific. Age requirements should be determined before approaching a child. Caseworkers should utilize the same strategies listed above for obtaining consent to obtain informed assent from children. When obtaining assent, caseworkers should ensure that information is delivered using child-friendly language (**Note:** *See Annex 13: Tool: Household Enrollment Form* for a sample consent to participate in the OVC program). This should be explained and signed prior to conducting the well-being assessment.

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[50] Global Protection Cluster, European Commission Humanitarian Aid & USAID (2014). Inter-Agency Guidelines for Case Management and Child Protection. Retrieved from: *http://www.socialserviceworkforce.org/system/files/resource/files/Interagency%20Guidelines%20for%20Case%20Management%20and%20Child%20Protection.pdf*

[51] *Ibid.*

[52] For more information on how to explain case management and case plan achievement to families, please see Annex 6: Reference: Case Management Assessment Framework.

[53] National Association of Social Workers (2017). Code of Ethics (revised). Retrieved from: *https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English*

[54] UNICEF (1989). Convention of the Rights of the Child: Guiding Principles. Retrieved from: *https://www.unicef.org/crc/files/Guiding_Principles.pdf*

ANNEX 11: Tool: Sample Household Vulnerability Prioritization Tool

HOUSEHOLD NUMBER (OFFICIAL USE ONLY)

Uganda Household Vulnerability Prioritization Tool (HVPT) [OVCMIS FORM 006]

The Uganda (HVPT is intended to assist OVC service providers in prioritizing households for OVC programmes or support. This tool should be applied to all households listed by Case Workers, para-social workers, Village Health Teams (VHTs), religious or local leaders, or other project staff under the guidance of Local Council 1 (LC.1) and verified by the Community Development Officer (CDO) using the criteria of the Pre-Identification and Registration Tool [OVCMIS FORM 005] or community mapping. It can also be applied to households coming from referrals. For further information on how to administer this tool and prioritise households, refer to the MGLSD guidelines for OVC identification, prioritization, monitoring, and graduation (2015).

INSTRUCTIONS FOR PERSON(S) ADMINISTERING THE HVPT:

1 | Start the interview by greeting and introducing yourself, the name of the OVC project, partners (e.g., MGLSD, MOH), and the purpose of the assessment. Say, *"We are asking people questions to assess vulnerability across a number of areas. This exercise asks for sensitive information on household finances, food, school enrollment, health and HIV status, psychosocial well-being, and child protection. It should take 15–20 minutes to complete."*

2 | Ask for permission to conduct the assessment. Ensure that the interviewee is clear that the assessment will not result in enrollment and services for the household. Say, *"Participation in this exercise does not guarantee enrollment in the project, but enables the project to identify and prioritise vulnerable households for support."*

3 | State that information shared is confidential and will only be used by Government or project staff for determining enrollment of the household and/or needed referral(s).

4 | After completing the HVPT, check that all questions have been answered and correct any errors in documentation. Note on the form if a referral is needed. In the case of severe issues (e.g., a child in danger or who has experienced a child protection issue, such as severe physical or sexual abuse), the situation should be reported immediately to the appropriate authorities (e.g., a local organization; a local council; in the case of child protection, a legal entity; or the toll-free national child helpline, SAUTI – 116).

5 | Return completed HVPT to designated officers (e.g., civil society organization (CSO) staff or Community Development Officers (CDOs) in areas where they are directly carrying out the activity) for household prioritization. Note that people who directly administer the tool should not make decisions about enrollment.

INSTRUCTIONS FOR EMERGENCY ACTION:

If any of the following conditions are identified within the assessed household, refer for immediate assistance within 24 hours:

- **Child abuse:** Escort child and caregiver to a child Case Worker based at a local police station or hospital.
- **Child is seriously ill and without access to treatment:** Escort the child and caregiver to nearest health facility and alert the local CDO.
- **Child is visibly malnourished**: Escort the child and caregiver to nearest health facility and alert the local CDO.
- **Submit the completed HVPT to the CDO/project officer within one week.**

BACKGROUND INFORMATION:

Name of the implementing partner:		
Name of OVC service provider:		
District:		
Sub-County/Division/Town Council:		
Parish/Ward:		
Village/Cell/Zone:		
Household Number (given by the project/CDO):		
Number of people aged 18+ currently living in household:	Male:	Female:
Number of children <18 years currently living in household:	Male:	Female:
Name, NIN, Unique Identifier, and Phone Number of interviewee (HH head or primary caregiver):	Name: NIN/Unique identifier: Phone Number:	
Name of person administering:	Title: Interview Date: Phone Number:	

INSTRUCTIONS:

Please administer the next section to the household (HH) head or his/her designee. Ask each question and circle the appropriate response option. If there is a situation where a referral is needed, put an "x" for "needs referral". Upon completion, return the form to the assigned programme officer where household prioritization will occur. After programme officers determine households for assessment, household enrollment and case planning will begin at the household level. See meaning of child abuse in SOPs.

	Priority Areas	Response			Needs Referral *(insert "x")*
ECONOMIC STABILITY AND SECURITY					
1	Is this a child-headed household? (The HH head is under 18)	Y	N		
2	In the last 6 months, has there been at least one member of the household who has consistently had formal or informal employment or is self-employed or has a business or is engaged in an economically productive activity?	Y	N		
3	The last time there was an unexpected, urgent household expense (e.g., emergency medical expense or house repair), was someone in the household able to pay for that expense?	Y	N	NA	
4	Does the HH head, spouse, or caregiver have any form of severe disability (e.g., hearing, speech, physical, mental, visual, genetic deficiencies (albinism)) that prevents him/her from engaging in economically productive activities?	Y	N		
Economic Stability and Security Vulnerable? *(If answer to #1 or# 4 is "Yes" or answer to #2 or #3 is "No", then circle "Yes")*		Y	N		---
SURVIVAL AND HEALTH					
5	Has the household eaten at least 2 meals a day, every day, for the last month?	Y	N		
6	In the last month, did any child in the household go a whole day without eating anything because there wasn't enough to eat? *(In case of visibly malnourished child, check yes and refer)*	Y	N		
7	Can household members fetch water for domestic use within half an hour?	Y	N		
8	Does the household have stable shelter that is adequate, safe, and dry? *(Please observe)*	Y	N		
9	Is there anyone in the household who is HIV+? *(If you already know the status, then check "Yes." Indicate the number of adults and/or children)*	Y	N	DK	
	Adults:	***Children:***			
10	Does the caregiver know the HIV status of everyone in the household? *(Skip if don't know status of anyone in the household. If "No" administer the risk assessment tool and refer)*	Y	N		
Survival and Health Vulnerable? *(If answer to #5, #7, #8 or #10 is "No", or if answer to #6 or #9 is "Yes", then circle "Yes")*		Y	N		---
EDUCATION AND DEVELOPMENT					
11	Are there any children aged 6–17 years in this household who are not enrolled in school?	Y	N	NA	
12	Are there any children aged 6–17 years in this household who are enrolled in school and have missed school for about 30 days in the last school term?	Y	N	NA	
13	Are there any children in this household who are withdrawn or consistently sad, unhappy, or depressed, and not able to participate in daily activities including playing with friends and family?	Y	N		
Education and Development Vulnerable? *(If answer to #11, #12 or 13 is "Yes", then circle "Yes")*		Y	N		---

CARE AND PROTECTION			
14	In the past 6 months (since: _____), has any child in the household had the following happen to him/her, in or outside of the household? *(If any item is ticked, circle "Yes")* *(Note: If you see an obvious issue of abuse or you already know about it, then you may check type of issue and circle "Yes" in the response column)* ☐ ***Teenage pregnancy*** ☐ ***Neglect*** ☐ ***Sexual abuse*** ☐ ***Physical abuse that causes body harm*** ☐ ***Child marriage or teenage mother/father***	Y	N
15	Is there an orphan in this household?	Y	N
16	Is there any child in this household who… …has not been registered at birth? …does not have a birth certificate or National Identification card?	Y	N
Care and Protecion Vulnerable? *(If answer to #14, #15 or 16 is "Yes", then circle "Yes")*		Y	N ---
TOTAL SCORE: *(Yes = 1; No = 0; Not Applicable = 0; Don't know = 0)*			

Assessor's Comments:

ANNEX 12: Reference: Sample Graduation Benchmarks for OVC Programming

The following benchmarks reflect what are considered **successful outcomes** of an OVC program. They represent the different criteria that can be used to measure achievement toward specific goals and related outcomes of both the OVC program and the household's case plan. The goals and benchmarks are aligned with the PEPFAR Global Minimum Benchmarks and the four domains encompassing OVC interventions: healthy, stable, safe and schooled.[55]

1 | **Healthy**: This domain 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, including HIV testing, care and treatment services to enable vulnerable children, especially girls, to stay HIV-free.

2 | **Stable:** This domain includes interventions that reduce economic vulnerabilities and increase resiliency in adolescents and families affected by and vulnerable to HIV.

3 | **Safe:** This domain includes interventions to prevent and mitigate violence, abuse, exploitation and neglect of children and adolescents, including sexual and gender-based violence.

4 | **Schooled:** This domain includes interventions to support children and adolescents affected by and vulnerable to HIV to overcome barriers to accessing education, including enrollment, attendance, retention and progression and/or transition.[56, 57] It also addresses vocational training in the case of some adolescents.

This document includes the following:

- ***Domain and name of the benchmark:*** This column highlights to which of the four domains (healthy, stable, safe and schooled) the benchmark corresponds, as well as a short name for the benchmark (e.g., HIV testing).
- ***Sub population:*** This column refers to the person or persons that this benchmark refers to and who will be part of sharing the information to validate if the benchmark has been reached. This can include the caregiver, child[ren] or both.
- ***Definition of the benchmark:*** This includes a clear description of this benchmark and to the specific goals of OVC programming to which it directly relates.
- ***Why the benchmark is important:*** This column contains information highlighting the evidence base supporting the benchmark, why it is critical to work toward achieving this benchmark, and why it is important in terms of OVC programming and the global effort toward reaching 95-95-95.
- ***How to verify achievement of the benchmark:*** This column includes suggestions regarding how the caseworker or implementing partner can verify whether or not the benchmark has been reached. There are multiple ways this can be done, and approaches or actions will differ depending on the benchmark.

[55] Benchmarks based on benchmarks originally developed by 4Children, and adapted and finalized by MEASURE Evaluation. This set of Global Minimum Benchmarks was published in February 2019.
[56] *Ibid.*
[57] PEPFAR (2015). Technical Considerations Provided by PEPFAR Technical Working Groups for 2015 COPS and ROPS.

#	DOMAIN AND NAME OF BENCHMARK	SUB-POPULATION	DEFINITION OF BENCHMARK	WHY IT IS IMPORTANT	HOW TO VERIFY
			HEALTHY		
1	***Healthy*** Increased diagnosis of HIV infection	All household members[58]	All children, adolescents, and caregivers in the household have known HIV status[59] or a test is not required based on risk assessment[60]	**This benchmark directly relates to the first *95-95-95*[61]** 1 | Children enrolled in the program and at risk of HIV must be tested for HIV before being considered for exit from the OVC program (i.e., case plan achievement).[62] Referral for testing is not sufficient as there must be documentation that the testing has occurred, and status is known by the OVC program.[63] Note that an HIV risk assessment may yield an outcome of "HIV test not required based on risk assessment." It is not required that every child receive an HIV test if risk factors are not present. However, risk factors should be routinely re-assessed. 2 | Caseworkers need to facilitate access to the HIV testing service. Facilitation could include: counseling children and caregivers about the importance of being tested; accompanying children to the HIV testing service; reaching out to a health worker trained in providing HIV testing services. 3 | Children considered at-risk of or especially vulnerable to HIV include children exposed to HIV (infants born of HIV+ mothers); children living with HIV+ caregiver (parent or other HIV+ household member); orphans (specifically in high HIV prevalence area); adolescent girls at-risk in high HIV prevalence geographic areas, not in school, at risk of abuse, violence and exploitation, including early marriage and including children of female sex workers (FSWs), high poverty and at risk of being exposed to HIV due to being involved in sexual relationships, especially in relationships with older men or those considered "transactional."	1 | Referral status should be documented in the case file. As with all personal information, confidentiality protocols and safekeeping of documentation must be ensured by the OVC program. 2 | If the child has been tested and is negative but presents one or more of the risk factors outlined in point 3 of the previous column of this benchmark, retesting is encouraged. 3 | Those at-risk for HIV will be identified using an HIV Risk Assessment[64] that is aligned to national guidance. 4 | HIV status (positive, negative, or unknown) is recorded in the case file of the child who is at-risk of HIV. [65] 5 | The OVC program facilitates the sharing of HIV test results through Memorandums of Understanding (MOUs) and standard operating procedures (SOPs) between the health facility (especially link desks) and the OVC program. 6 | Community health volunteers (CHVs), community mentor mothers or social workers working with the OVC program are able to check the Comprehensive Care Cards of household members.

[58] Members of the household considered as targeted by the benchmarks include all children and primary caregiver[s].
[59] This benchmark specifically refers to the caregiver knowing his/her status and the HIV status of the child[ren] in their care and sharing that information with the OVC program. A benchmark for disclosure to the child about his/her own status is a separate benchmark.
[60] OVC Programs in Kenya are using the HIV Risk Screening Tool to determine if a child is considered at risk for HIV and should be tested.
[61] MER 2.0 Reference guide. Accessed from: *https://www.pepfar.gov/documents/organization/274919.pdf*
[62] PEPFAR Technical Considerations for COP/ROP 2016. "As HTS programs are unlikely to offer HIV testing to all OVCs, PEPFAR teams should clearly describe a plan of how they will target at-risk OVC (e.g., those who are clinically ill, have regularly missed school, or who have at least one parent deceased due to HIV and AIDS or a chronic illness)." Accessed from: *http://www.pepfar.gov/documents/organization/252263.pdf*
[63] It is strongly recommended that the OVC program ensure an established procedure for receiving parental consent to share the testing results of children and caregivers with the OVC. This should be a Standard Operating Procedure of the OVC program that is clearly explained to and understood by the caregiver at the beginning of the case management process.
[64] MEASURE Evaluation developed an *HIV Risk Assessment prototype* that implementing partners may adapt to assess risk among orphans and vulnerable children.
[65] When documenting the status of HIV testing results (positive or negative) in the case file, confidentiality needs to be ensured, including safekeeping by the CSO/NGO providing the OVC services.

#	DOMAIN AND NAME OF BENCHMARK	SUB-POPULATION	DEFINITION OF BENCHMARK	WHY IT IS IMPORTANT	HOW TO VERIFY
2	***Healthy*** Increased HIV treatment adherence, retention and viral suppression	HIV+ household members (caregivers and children)	(a) All HIV+ children, adolescents, youth, and primary caregivers in the household with a viral load result documented in the casefile have been virally suppressed (<1,000 copies/mL) for the past 12 months.[66, 67] *Or if viral load testing results are not documented in the casefile*: (b) All HIV+ children, adolescents, youth, and primary caregivers in the household have adhered to ART for at least the last 12 months.[68]	**This benchmark directly relates to the second *95-95-95*** 1 | It is essential that all children and their caregivers who have tested positive for HIV are on treatment. This means having consistent access to ART and remaining on treatment. This is the way in which their viral load is suppressed (**Note:** *See Annex 21: Job Aid: What is Viral Load and How to Discuss it*). 2 | People living positively need to be on treatment at least 12 months before being considered for successful exit from the OVC program to address some of the challenges associated with adhering to ART. 3 | Adolescents living with HIV who are at the age at which they are eligible for treatment in the adult clinic should be successfully transitioned to the adult clinic prior to being considered for successful exit from the OVC program. 4 | Pregnant and breastfeeding women living in settings where HIV incidence is high often remain at increased risk of HIV acquisition during pregnancy and breastfeeding. Pregnant and breastfeeding women who acquire HIV at this time have a greater risk of transmitting HIV to their infants than women who became infected with HIV before pregnancy.[69] 5 | As such, an HIV-positive woman who has a baby should not be considered for exit until the child is at least six months old and has received the DNA PCR test, but ideally remains in the program until the child reaches 18 months (i.e., completion of breastfeeding) and has received results of final HIV test.	1 | Primary caregivers report ART adherence for themselves and children in their care. Adolescents and youth may report their own ART adherence based on national guidelines. 2 | Option (a) *or* (b) is used based on whether viral load testing results have been documented in the casefile: **(a)** If recent viral load testing results are documented in the beneficiary's casefile, the caseworker should use the casefile to assess whether the beneficiary has been virally suppressed (<1,000 copies/mL) for the past 12 months. **(b)** If recent viral load testing results are not documented in the beneficiary's casefile, the caseworker should use the casefile to assess whether the beneficiary has done the following in the past 12 months: ▪ Regularly attended ART appointments and picked up ART pills on schedule *and* ▪ Taken ART pills as prescribed 3 | The casefile must show that the beneficiary was meeting these criteria at every monthly or quarterly visit in the past 12 months.

[66] Beneficiaries whose earliest viral load test result was <12 months ago are ineligible to meet this benchmark.

[67] The OVC program is NOT responsible for doing viral load testing or even knowing specific numbers related to the viral load of each member of the household; however, the OVC program can support the facility by asking simple questions that will determine if caregivers or children are following their treatment regimens, know what viral status is, including their own, or if there is cause for concern. This will then be shared with the facility.

[68] Beneficiaries who initiated ART <12 months ago and those with a break in adherence during the 12-month period are ineligible to meet this benchmark.

[69] The 2016 WHO consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection consider the use of pre-exposure prophylaxis (PrEP) during pregnancy and breastfeeding and state that, in PrEP trials, exposure to PrEP during the first trimester of pregnancy was not associated with adverse pregnancy or infant outcomes. Thus, the WHO guidelines concluded that in such situations the risk of HIV acquisition and accompanying increased risk of mother-to-child HIV transmission outweigh any potential risks.

#	DOMAIN AND NAME OF BENCHMARK	SUB-POPULATION	DEFINITION OF BENCHMARK	WHY IT IS IMPORTANT	HOW TO VERIFY
3	***Healthy*** Knowledgeable about HIV prevention	Adolescents, 10-17 years of age	All adolescents 10-17 years of age in the household have key knowledge about preventing HIV infection	1 | Adolescent girls are recognized as a highly vulnerable group. 2 | Evidence of early sexual debut, sexual abuse and transactional sex all contribute to increased HIV risk, as well as protection concerns. 3 | Limited knowledge of and access to information on sexual and reproductive health and HIV increase vulnerability. 4 | Improved communication between adolescents and caregivers has shown a decrease in risky behavior and violence within the home.	1 | Self-report from the caregiver and the adolescent (separately, if possible) in which caregivers and adolescents have discussed HIV prevention/sexual and reproductive health. 2 | Adolescent are asked[70] to: a. Describe at least two HIV infection risks in their local community *and* b. Provide at least one example of how they can help protect themselves against HIV risk. 3 | Caregiver and adolescents can articulate ways to reduce their vulnerability to HIV infection. Ideally, this is done separately if the context or situation allows. 4 | Evidence of completed evidence-based parent training (with HIV/sexual and reproductive health modules) by caregivers and evidence of completed evidence-based HIV prevention training by adolescents (e.g., list of participants, certificate of completion).
4	***Healthy*** Children in the household are not undernourished	Children <5 years of age	All children <5 in the household exhibit appropriate nutritional development	1 | Adequate nutrition helps to build children's immune systems and decreases the risk of illness. Good nutrition is particularly important for the health of children living with HIV and children taking regular medications, such as ART.	1 | For a child 6-59 months., a trained caseworker or health worker should assess mid-arm circumference (MUAC) and bipedal edema. For a child under the age of 6 months, a caseworker or health worker should visually examine the child to determine whether the child appears undernourished.

[70] The caseworker should use the *Graduation Benchmarks Assessment Tool*, adapted to align with National guidance, with each household to assess this domain of graduation readiness.

#	DOMAIN AND NAME OF BENCHMARK	SUB-POPULATION	DEFINITION OF BENCHMARK	WHY IT IS IMPORTANT	HOW TO VERIFY
			STABLE		
5	***Stable*** Improved financial stability	Caregivers	Caregivers can access money (without selling productive assets) to pay for school fees and medical costs for children 0-17	1 | This benchmark captures the household's improved ability to meet expenses associated with children's needs, such as the cost of food, education, medical expenses, clothing, etc. 2 | Caregivers should demonstrate that they prioritize education, health care and basic food and shelter, and have the funds to do so whether their own funds / resources, cash transfers, or bursaries are used.	1 | The primary caregiver should be asked the following questions (captured in the *Graduation Benchmark Assessment Tool*) ▪ Were you or another caregiver in the household able to pay school fees for the last school year for all children and adolescents in your household under the age of 18? ▪ Were you able to pay for these school fees without using a PEPFAR cash transfer, grant, or scholarship from [name of CBO or OVC project]? ▪ Were you able to pay for these school fees without selling something used to generate income that you did not plan or want to sell, such as livestock, land of agriculture, tools, or equipment for a business? ▪ Were you or another caregiver in the household able to pay all medical costs in the past 6 months for all children and adolescents in your household under the age of 18? Medical costs include medicine, clinic fees, and transport to medical appointments. ▪ Were you able to pay for these medical costs without using a PEPFAR cash transfer or grant from [name of CBO or OVC project]? ▪ Were you able to pay for these medical costs without selling something used to generate income that you did not plan or want to sell, such as livestock, land for agriculture, tools, or equipment for a business?

#	DOMAIN AND NAME OF BENCHMARK	SUB-POPULATION	DEFINITION OF BENCHMARK	WHY IT IS IMPORTANT	HOW TO VERIFY
			SAFE		
6	***Safe*** Reduced risk of physical, emotional, and psychological injury because of exposure to violence	Caregivers, children and adolescents	No children, adolescents, and caregivers in the HH report experiences of violence (including physical violence, emotional violence, sexual violence, gender-based violence, and neglect) in the last 6 months.	1 | Children affected by HIV are at increased risk of violence (gender-based violence), and other forms of exploitation, neglect and abuse. 2 | The caregiver should know the signs of abuse and violence and where to seek help, if needed.	1 | Self-report[71] from female, primary caregiver on her experience of violence as wekk as violence experienced by children, adolscents, and youth in the household. 2 | Evidence of completed referrals to relevant health, protection or legal services is included in the case file and confirmed by the CHV.
7	***Safe*** Not in a child-headed household.	Children and adolescents	All children and adolescents in the household are under the care of a stable adult caregiver.	1 | Children-headed households face many stressors including economic, emotional distress, social isolation, risk of dropping out of school and possibly sexual exploitation. All of these factors can place children at increased risk of HIOV and negatively impact the health of children living with HIV.	1 | Using the casefile and their knowledge of the HH, the caseworker determines whether, in the past 12 months, all children and adolescents in the household have been under the care of a stable adult caregiver.
			SCHOOLED		
8	***Schooled*** Regular attendance, retention and progression in school, including primary, secondary or vocational	All children and adolescents, ages 6-17, in the household	All school-age children and adolescents in the household regularly attended school and progressed during the last year.	1 | Children ages 6-17 years from the OVC programs need to be enrolled in primary or secondary school, attend school regularly before being considered ready for graduation, and the household must demonstrate ability to continue meeting school expenses. 2 | Attending school regularly is defined as not missing school more than five days per month. 3 | Adolescents enrolled and currently receiving support from the project will be graduated on completion of the course, or if the household demonstrates ability to continue meeting school expenses.	1 | The caseworker should ask the caregiver the pertinent questions from the *Graduation Benchmarks Assessment Tool*, and review school report cards or other evidence that shows school attendance.

[71] The caseworker should use the *Graduation Benchmarks Assessment Tool*, adapted to align with National guidance, with each household to assess this domain of graduation readiness.

ANNEX 13: Tool: Household Enrollment Form

INSTRUCTIONS: This form should be completed by the head of the household. "Y" means yes and "N" means no.

My household agrees to regularly meet with _____ *(caseworker)* to discuss issues that we face, set goals for our future, and plan how to achieve those goals until our goals are reached.

Y N

(These actions together can also be called "case management.")

I allow our information to be stored in _____ (CSO) case management system.

Y N

(This means that the CSO will keep information about your case, such as a record of your participation and progress made during case management, in a safe place. Only the people that you indicate below may access this information.)

I allow specific information on my household's information to be shared with and discussed during case conferencing with the service provider[s] (organizations or groups) I have agreed to be referred to help my family and me achieve our goals. I understand that shared information will be treated with confidentiality and respect, and shared only on a need-to-know basis to provide the assistance I request or need.

Y N

(If applicable) I would *not* like my information to be shared with the following:

Reason:

I understand that I can change my mind and decide not to share information.

Y N

I understand that in life-threatening or emergency situations our information will be shared with the necessary authorities whether or not I have given consent. *(Life-threatening situations or emergency situations include but are not limited to cases of child abuse, violence, neglect or exploitation.)*

Y N

_____ _____

Signature of caregiver *Signature of community witness (as appropriate)*

Date: / /

ANNEX 14: Job Aid: Data Protection Protocols[72]

Confidentiality, Documentation, Record Filing and Information Sharing

Data protection relates to the protection of all personal data collected, either through individual discussions as well as the receipt of secondary data. Agencies involved in case management must develop data protection protocols based on the principles of confidentiality and "need to know,"[73] 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 case management process should be aware of the data protection protocols.[74]

CONFIDENTIALITY

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

CONFIDENTIALITY AND CLIENT CONSENT

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

Confidentiality protocols should be based on the understanding that the child/family owns the case information and that only with the **family's consent** (child's assent) can the information be shared beyond the case management relationship, unless ordered by an authorized statutory entity such as a court.

During enrollment, the caseworker should ensure that family consent is received and documented. The implications of sharing this information should be fully explained. **Examples of a confidentiality policy and form** for all caseworkers to sign can be found at the end of this job aid.

[72] Adapted from: 4Children (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 Ministry of Gender Equality and Child Welfare (2017). Child Protection Case Management Operations Manual

[73] 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 in order to provide services to the family and children. Any sensitive and identifying information collected on families and children should only be shared on a need-to-know basis with as few individuals as possible.

[74] Child Protection Working Group (2014). Inter-Agency Guidelines for Case Management & Child Protection.

DOCUMENTATION AND RECORD KEEPING

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

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

1 | CASE FILES

Individual family case files should be created for each case, based on the individual family, and include documents for each child within the family with key information presented in a standard, structured way. A case file should include the standard forms and case notes that document each step of the case management 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 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 caseworkers, supervisors, monitoring and evaluation, and program staff. The staff retrieving the file should complete a register. Below is an example that can be used.

CLIENT NAME	UNIQUE IDENTIFIER	NAME OF CASEWORKER REQUESTING THE FILE	DATE OF FILE RETRIEVAL	DATE OF FILE RETURN
			/ /	/ /

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 has removed it.

2 | UNIQUE IDENTIFIER

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

The code should be used to refer to the child's case either verbally, on paper or electronically (including in Word documents, emails, Skype conversations, etc.) in place of any identifiable information, such as 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. Below is a sample unique identifier system if no government or organizational system exists.

SAMPLE UNIQUE IDENTIFIER CODING SYSTEM

Many countries have national data management systems. If an OVC project is expected to report into such a system, unique identifier codes should be assigned per the national protocol. If no such system exists, the following is a proposed method for assigning unique identifier codes.

The caseworker should start with the first two letters of the area where the household lives. For example, if the family lives in Abuja, then the first two letters would be AB.

Following the first two letters of the location, the caseworker should note the date of enrollment. For example, if the household was enrolled on April 6, 2017, then the caseworker should write AB06042017.

After writing the date, the caseworker should indicate the number of households that have been enrolled on that day. For example, if the caseworker enrolled two households on April 6, 2017, and this is the second family, then she/he should write AB060420172. This is the unique identifier code of the entire family. This code will be used at the CSO to store the family's folder.

To distinguish between members of the household, the caseworker should organize them according to age and assign each family member a number. For example, if there were four family members in the second household enrolled on April 6, 2017, then the unique identifier code for the oldest member of the household should be AB060420172-1. The unique identifier code for the youngest member of the household should be AB060420172-4.

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 **changed on a regular basis**. Information should be transferred by **encrypted or password-protected files** whether this is by internet or memory sticks. Memory sticks (USBs) should be passed by hand between people responsible for the information and should also be password protected; the file should be erased immediately after transfer. Ensure that the file is also permanently erased from the recycle bin file of your computer.

A regular backup system should be in place. Typically, an on-site backup is done on an external hard drive, which is kept locked in a filing cabinet. Ideally, a second off-site backup in a second location (for example, head office) should be set up for secure storage in a predefined centralized location. The reason for having an off-site backup is so that the data can be retrieved if the main database becomes damaged. The off-site backup is often done through electronic sharing of the database to 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 case management related training and capacity-building activities to ensure they understand the processes, and especially data protection/confidentiality issues.

INFORMATION SHARING PROTOCOLS

As multiple agencies or government departments are working together to address the needs of families and children through the provision of multiple services and referral pathways, it is essential to also develop **agreed-upon information-sharing protocols** that define what information about the family 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 family and child is protected and respected at all times.[75]

Confidentiality agreements need to be signed when confidential information is being shared among multidisciplinary actors participating in an integrated case management effort, such as case conference. An example of a **confidentiality agreement** for case conference meetings can be found at the end of this job aid.

CONFIDENTIALITY POLICY

Confidentiality is the preservation of privileged information. The information learned from work with a family and children is necessary to provide services to the child or family, and 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 4Children project generally, and about the program and your position, but you are not permitted to disclose child, caregiver or family names, locations or to talk about them in ways that will make their identity 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.

4Children expects you 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 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.

CERTIFICATION

I have read the 4Children policy on confidentiality. I agree to abide by the requirements of the policy and 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: / /

[75] Child Protection Working Group (2014). Inter-Agency Guidelines for Case Management & Child Protection.

CONFIDENTIALITY AGREEMENT FORM
(for case conference meetings)

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 _____ *(position title)* and member of the case conference meeting. I understand that it is a violation of policy to disclose such information to anyone outside of the care conference meeting membership.

_____ _____

Signature of Member *Name of Member*

Date: / /

ANNEX 15: Tool: Caregiver and Child Well-being Assessment

Note about bold and circled questions:

- Any questions that have **circles** relate to graduation benchmarks.
- Any questions that are **bolded** are considered essential questions and should not be removed during any adaptation process.

Note to caseworker: If any of the questions below may be answered based on the results of the Household Vulnerability Prioritization Tool or other documents contained within the family's case file, the caseworker should fill out those responses beforehand. Questions with a circle are connected to one or more graduation benchmarks.

	DEMOGRAPHIC QUESTIONS *"I'm going to begin by asking you some basic questions about yourself, your family and your assets."*	
1	**Record caregiver's unique identifier code**	
2	**What is your name?**	
3	**Date of assessment**	_____ / _____ / _____
4	**Name of caseworker (CHV)**	
5	**Record caregiver's sex**	☐ Male ☐ Female
6	**How old are you?**	_____ years
7	**What is your birth date?**	_____ / _____ / _____
8	**What is your address?**	
9	**What is your phone number?**	**(** _____ **)** _____ - _____
10	**What is your marital status?**	☐ Monogamous marriage ☐ Polygamous marriage ☐ Living with a partner ☐ In partnership, not living with partner ☐ Single ☐ Widowed ☐ Divorced
11	**How many children (below age 18) are you responsible for?**[76]	_____ children
12	**How many people in total make up your household?**	_____ people
13	**Are there any adults in the household other than you? <u>If yes</u>, how many adult males and females (other than you) live in your household?**	☐ Yes _____ males ☐ No _____ females
14	Are any other adults in the household already enrolled in the program?	☐ Yes ☐ No

[76] This question was adapted from the Pact-MEASURE Evaluation OVC Questionnaire for Primary Caregivers.

	Question	Response	Action for Service Provision
	Caseworker reads: *"Assets are things or relationships that are useful and valuable to you. For example, they can be people because each person has knowledge, skills and talents."*		
15	**How do you help your family? For example, do you cook or make items such as clothes or tools? What skills or talents do you have?**		
16	**If applicable, how do the other adults in your household or community help you? For example, do they help you care for the children or earn extra income?**		
	DOMAIN: STABLE		
	Caseworker reads: *"Assets can also be material goods. For example, items that make life easier or better."*		
17	**What kinds of material goods do you have? For example, do you have pots to cook with and tools for making repairs and/or growing food?**		
18	**Are you employed? If yes, is your work regular (you work every week) or irregular (you work only some weeks or during some seasons)?**	☐ Yes ☐ Regular ☐ No ☐ Irregular	
19	**In the last 6 months have you been able to save money?**	☐ Yes ☐ No	
20	If today you had an unplanned expense for the family, for example food, schooling or healthcare, how would you respond in meeting this need?	☐ My salary ☐ My savings ☐ Loan from family or friend ☐ Loan from a microcredit group ☐ Loan from a money lender ☐ Hawking/market vending ☐ Sale of family assets ☐ Unable to meet unplanned needs	*If anything different from salary and savings connect the household to SILC group.*
21	Are there other resources in the household that you can use to meet urgent or unplanned family needs? For example, assets that can be used to raise funds as needed, such as cows that produce milk, chickens that produce eggs, or a motorcycle that could be used as a taxi)? *If yes*, what are these assets?	☐ Yes ☐ No _____ _____ _____	
22	**Are you a member of a savings group?**	☐ Yes ☐ No	*If no, refer to SILC group.*
23	**Do you participate in any programs such as cash transfer, food support, school bursaries or other programs related to health, education or nutrition?** ***If yes*, which ones?**	☐ Yes ☐ No _____ _____	*If necessary, link the household to the services they are not accessing.*
24	**In the past month, has any member of your household gone a day without eating because of a lack of resources to get food?**[77]	☐ Yes ☐ No	*If yes and not already participating, refer for food support.*

[77] Ibid.

DOMAIN: HEALTHY			
Caseworker reads: *"Your health can also be asset to you and your family because it allows you to work and take care of your house and children."*			
25	**In the last month, have you gone more than three days when you were too sick or too tired to participate in daily activities?** ***If yes*, how long did this problem last?** **Have you received medical treatment for this problem?** **If yes, what is the name of the service provider?**	☐ Yes ☐ No ☐ 1 week ☐ 1-4 w ☐ 1-3 months ☐ 3-6 m ☐ 6m - 1 year ☐ >1 year ☐ No response ☐ Yes ☐ No ☐ Refuse to respond _____	*If a medical problem exists and treatment has not been received, refer for treatment.*
26	**Do you have a disability or long-term illness that you would like to share with me? If yes, list the response** **If yes to either illness or disability, are you currently receiving treatment for your illness or disability? If yes, from whom?**	☐ Yes ☐ No _____ ☐ Yes ☐ No _____	*If a disability or illness exists and treatment has not been received, refer for treatment.*

Caseworker reads: *"Now I am going to ask you a few questions about HIV. If you feel uncomfortable answering any of them, you can say you do not want to respond. All of your answers will be private."*

27	**Do you know your HIV status?** **If no, have you ever been tested for HIV?**	☐ Yes ☐ No ☐ Refuse ☐ Yes ☐ No ☐ Refuse	
28	**If yes, are you willing to share with me your status? Record HIV status.**	☐ HIV + ☐ HIV - ☐ Indeterminate ☐ Unknown ☐ Refuse	
29	**If the adult said he/she is HIV-positive: Are you currently taking ART to treat HIV?** *The caseworker should ask for the container of the drugs and check the drugs.*	☐ Yes ☐ No ☐ Refuse	*If no, refer to HIV care and treatment services.*
30	**If the adult is taking ART: do you take your treatments regularly and on time?**	☐ No, too many side effects ☐ No, treatment not regularly available ☐ No, scared that someone will find out that I'm living with HIV ☐ No, it's hard to remember ☐ Yes, I take it on time and regularly ☐ Yes, but not regularly ☐ Other, please specify: _____ _____	*If anything other than "Yes, I take it on time and regularly," provide information on why regularly taking ART is important.*

31	**If the adult is taking ART: which health facility do you visit?** **Why did you choose this health facility?**	☐ It's the only place I can get treatment ☐ It's easy to access ☐ I'm afraid my family will learn my status ☐ I'm afraid that my neighbors will discover my status ☐ The doctor at the health facility closest to me doesn't treat me well	
32	**If the adult said they are HIV-positive: have you disclosed your status to anyone? If yes, to whom?**	☐ Yes ☐ No	*If no, refer to HIV support services.*
33	If yes: do you feel like people treat you differently because you are HIV-positive? If yes, how have you coped with HIV-related stigma?	☐ Yes ☐ No ☐ Refuse ☐ I am part of a self-support group ☐ I speak with people who I am close with or my family ☐ I speak with my doctor ☐ I speak with my pastor or priest ☐ I face it all alone ☐ I avoid thinking about it because it's too difficult ☐ I do not face stigma ☐ Other:	*If yes, refer to HIV support group or psychosocial support.*

DOMAIN: SAFE

Caseworker reads: *"Assets can also be social. This is because people need connections, support and relationships in order to be well."*

34	**What organizations or community groups do you participate in?[78] Read responses. Multiple responses possible**	☐ HIV support group ☐ Women's group ☐ Church/religious group ☐ Parent's/caregivers' group ☐ Community savings group ☐ Trade association or business group ☐ Political group ☐ None ☐ Other (specify):	
35	**Is there someone or a group of people (for example, family, friends or neighbors) in your community that you trust and feel that you can talk with about any problems that you may face? If yes, with whom can you talk?**	☐ Yes ☐ No	

[78] This question has been adapted from the Pact-MEASURE Evaluation OVC Questionnaire for Primary Caregivers.

36	If you had to quickly run an errand or leave your house for a few hours, is there someone that you could ask to watch your children?	☐ Yes ☐ No	
37	**In the last six months have you received training or information on parenting/child care and development through training, counseling, mentoring or home visits?**[79] **If yes, who or which group provided the training/information?**	☐ Yes ☐ No _____ _____	*If the caregiver has not received information on parenting, refer to a parenting skills group.*
38	**Have you ever experienced violence in your home?** **If yes, did you report this violence?** **If yes, to whom did you report it?** **If you reported it, what kind of support did you receive (if any) and from whom?**	☐ Yes ☐ No ☐ Yes ☐ No _____ _____	*If there is violence in the household, immediately refer to appropriate services.*
39	How do you feel about your ability to make change in your life?	☐ Not confident ☐ Unsure ☐ Neutral ☐ Confident ☐ Very confident	

[79] Ibid.

Note: A caregiver should respond to the following questions for all children (print as many copies of these pages to ensure all information is collected for all children).

Caseworker reads: *"I'm going to begin by asking some basic questions about each of the children in your household."*

	40	41	42	43	44	45	46	47	48	49
	Child's name	**Child's unique identifier code**	**Sex**	**How old was the child at her/his last birthday?**	**What is the child's date of birth?**	**What is your relationship to the child?** *(Use coding below)*	**If applicable, record other caregiver's unique identifier code.**	**What is his/her relationship to the child?** *(Use coding below)*	**If the mother is not a primary caregiver, where is the child's mother?**	**If the father is not a primary caregiver, where is the child's father?**
1			☐ Male ☐ Female	_____ years	___ / ___ / ___				☐ Live/work elsewhere ☐ Dead ☐ Other (specify) _____	☐ Live/work elsewhere ☐ Dead ☐ Other (specify) _____
2			☐ Male ☐ Female	_____ years	___ / ___ / ___				☐ Live/work elsewhere ☐ Dead ☐ Other (specify) _____	☐ Live/work elsewhere ☐ Dead ☐ Other (specify) _____
3			☐ Male ☐ Female	_____ years	___ / ___ / ___				☐ Live/work elsewhere ☐ Dead ☐ Other (specify) _____	☐ Live/work elsewhere ☐ Dead ☐ Other (specify) _____
4			☐ Male ☐ Female	_____ years	___ / ___ / ___				☐ Live/work elsewhere ☐ Dead ☐ Other (specify) _____	☐ Live/work elsewhere ☐ Dead ☐ Other (specify) _____

Use the following codes to indicate relationship to the child: *Mother (1); Father (2); Aunt (3); Uncle (4); Grandmother (5); Grandfather (6); Older sibling (7); Other relative (8) Other (specify)*

		50	51
	Child's name	**How do you see this child's role in the family? Read the responses.**	**How does [child's name] help your family? For example, does he/she help you with household chores or tending to animals? Can [child's name] read?**
1		☐ A source of joy ☐ Helps with household tasks ☐ Helps take care of the other children ☐ A source of worry ☐ Other, please specify: _____ _____	
2		☐ A source of joy ☐ Helps with household tasks ☐ Helps take care of the other children ☐ A source of worry ☐ Other, please specify: _____ _____	
3		☐ A source of joy ☐ Helps with household tasks ☐ Helps take care of the other children ☐ A source of worry ☐ Other, please specify: _____ _____	
4		☐ A source of joy ☐ Helps with household tasks ☐ Helps take care of the other children ☐ A source of worry ☐ Other, please specify: _____ _____	

DOMAIN: SCHOOLED

		52	53	54	55
	Child's Name	**Is [name of child] currently enrolled in school?**	**If the caregiver responded no, has the child ever been enrolled in school?** Caseworker: Enroll child in school	**Record why the child is not enrolled in school.** *Use following code to answer below: Sick/ Fever (1); Exhaustion (2); Housework (3); Fear of the school or other children at school (4); Fear of the walk to school (5); Inability to pay school fees (6); Inability to pay for school materials (7)*	**If the caregiver responded yes, what grade/form/year is [name of child] in now?**
1		☐ Yes ☐ No	☐ Yes ☐ No	Use code above: _____ Or specify if other: _____	_____ grade/form/year
2		☐ Yes ☐ No	☐ Yes ☐ No	Use code above: _____ Or specify if other: _____	_____ grade/form/year
3		☐ Yes ☐ No	☐ Yes ☐ No	Use code above: _____ Or specify if other: _____	_____ grade/form/year
4		☐ Yes ☐ No	☐ Yes ☐ No	Use code above: _____ Or specify if other: _____	_____ grade/form/year

		56	57	58
	Child's Name	**What grade/form/ year was [name of child] in last year?** Caseworker: If a child is not progressing in school, follow up to understand why not, and in the case plan include action steps for addressing this.	**If the child is enrolled in school, during the last month, did [name of child] miss more than three days for any reason?** *Use following codes to answer below: Fear of the teacher (1); Fear of the other children (2); Feeling lonely (3); Bored (4); Other (5)*	Does [name of child] like to go to school? *Use following codes to answer below: Fear of the teacher (1); Fear of the other children (2); Feeling lonely (3); Bored (4); Other (5)*
1		_____ grade/form/year	☐ Yes If yes, why? Use code above: _____ ☐ No Or other, specify: _____	☐ Yes If no, why? Use code above: _____ ☐ No Or other, specify: _____
2		_____ grade/form/year	☐ Yes If yes, why? Use code above: _____ ☐ No Or other, specify: _____	☐ Yes If no, why? Use code above: _____ ☐ No Or other, specify: _____
3		_____ grade/form/year	☐ Yes If yes, why? Use code above: _____ ☐ No Or other, specify: _____	☐ Yes If no, why? Use code above: _____ ☐ No Or other, specify: _____
4		_____ grade/form/year	☐ Yes If yes, why? Use code above: _____ ☐ No Or other, specify: _____	☐ Yes If no, why? Use code above: _____ ☐ No Or other, specify: _____

DOMAIN: STABLE

		59	60	61
	Child's Name	**Record any signs of malnutrition** Caseworker: If signs of malnutrition, refer to the clinic for nutritional status evaluation.	**In the past month, has [name of child] ever gone to bed hungry?** Caseworker: If yes, refer for nutritional support.	**If yes, how often would you say this happens?**
	Use following codes for sign of malnutrition: *emaciated and dry skin=1; dry hair=2; looking very tired=3; not playing=4; extremely thirsty=5; wounds not healing=6* | ***In particular, for children under 5:*** *swollen face and legs=7; red-orange colored hair=8*			
1		Use code above: _____ Or specify if other: _____	☐ Yes ☐ No	☐ Every night ☐ A few nights/week ☐ A few nights/month
2		Use code above: _____ Or specify if other: _____	☐ Yes ☐ No	☐ Every night ☐ A few nights/week ☐ A few nights/month
3		Use code above: _____ Or specify if other: _____	☐ Yes ☐ No	☐ Every night ☐ A few nights/week ☐ A few nights/month
4		Use code above: _____ Or specify if other: _____	☐ Yes ☐ No	☐ Every night ☐ A few nights/week ☐ A few nights/month

		62	63	64
	Child's Name	During the past month, did [name of child] receive nutritional supplements from a health clinic?	If yes, which kind of supplement did [name of child] receive?	What assets or material goods does this child have? For example, does [name of child] have a bed or clothing?
1		☐ Yes ☐ No ☐ I don't know ☐ Refuse	☐ Iron supplement ☐ Therapeutic nutrition (Plumpy Nut) ☐ Vitamin A ☐ Other (specify): _____	
2		☐ Yes ☐ No ☐ I don't know ☐ Refuse	☐ Iron supplement ☐ Therapeutic nutrition (Plumpy Nut) ☐ Vitamin A ☐ Other (specify): _____	
3		☐ Yes ☐ No ☐ I don't know ☐ Refuse	☐ Iron supplement ☐ Therapeutic nutrition (Plumpy Nut) ☐ Vitamin A ☐ Other (specify): _____	
4		☐ Yes ☐ No ☐ I don't know ☐ Refuse	☐ Iron supplement ☐ Therapeutic nutrition (Plumpy Nut) ☐ Vitamin A ☐ Other (specify): _____	

DOMAIN: HEALTHY

		65	66	67	68
	Child's Name	Do you have a card where [name of child] vaccinations are written down?[80] If yes, ask to see it.	Record immunizations from the child's card.	Would you say [name of child] is healthy and strong?	**In the last month, has [name of child] gone more than one day when he/she was too sick or too tired to participate in daily activities?**
1		☐ Yes ☐ No ☐ Don't know		☐ Yes ☐ No	☐ Yes ☐ No
2		☐ Yes ☐ No ☐ Don't know		☐ Yes ☐ No	☐ Yes ☐ No
3		☐ Yes ☐ No ☐ Don't know		☐ Yes ☐ No	☐ Yes ☐ No
4		☐ Yes ☐ No ☐ Don't know		☐ Yes ☐ No	☐ Yes ☐ No

		69	70	71
	Child's Name	**Does [name of child] have an illness or disability that you would like to share with me?**	**If yes, to either illness or disability, is [name of child] currently receiving treatment for the illness or disability?** Caseworker: If no, refer for treatment.	**If yes, what kind of services or treatment does [name of child] receive and from whom does [name of child] receive these services?**
1		☐ Yes ☐ No If yes, list illness or disability: _____	☐ Yes ☐ No	
2		☐ Yes ☐ No If yes, list illness or disability: _____	☐ Yes ☐ No	
3		☐ Yes ☐ No If yes, list illness or disability: _____	☐ Yes ☐ No	
4		☐ Yes ☐ No If yes, list illness or disability: _____	☐ Yes ☐ No	

[80] This question has been adapted from the Pact-MEASURE Evaluation OVC Questionnaire for Primary Caregivers.

Caseworker reads: *"Now I am going to ask you a few questions about HIV and your child. If you feel uncomfortable answering any of them, you can say you do not want to respond. All of your answers will be private."*

		72	73	74
	Child's Name	**Do you know [name of child]'s HIV status?**	**If no, has [name of child] ever been tested to see if he/she has HIV?**	**If the caregiver responded yes: I would like to ask you the result of [name of child]'s latest HIV test, but I want to remind you again that you should only answer the question if you feel comfortable. If you feel comfortable, could you tell me the result of [name of child]'s latest HIV test?[81]**
1		☐ Yes ☐ No	☐ Yes ☐ No	☐ Positive ☐ Negative ☐ Indeterminate ☐ Don't Know ☐ Refuse
2		☐ Yes ☐ No	☐ Yes ☐ No	☐ Positive ☐ Negative ☐ Indeterminate ☐ Don't Know ☐ Refuse
3		☐ Yes ☐ No	☐ Yes ☐ No	☐ Positive ☐ Negative ☐ Indeterminate ☐ Don't Know ☐ Refuse
4		☐ Yes ☐ No	☐ Yes ☐ No	☐ Positive ☐ Negative ☐ Indeterminate ☐ Don't Know ☐ Refuse

		75	76	77
	Child's Name	**If the caregiver said the child is HIV positive: Is [name of child] currently taking ART to treat HIV?** Caseworker: Ask for the container of the drugs and check the drugs. If the child is positive and not taking ART treatment, refer for HIV services.	**If the child is currently taking ART to treat HIV: To which health clinic do you take the child?**	Why does [name of child] go to this clinic? **Use following code for reason the child goes to this clinic:** It's the only place where child treatment is offered (1); It's the same place where I go for services (2); There's a good doctor at this clinic (3); I'm afraid that my family will learn the status of my child (4); I'm afraid that my neighbors will learn the status of my child (5); The doctor at the clinic near us doesn't treat us well (6)
1		☐ Yes ☐ No ☐ Don't Know ☐ Refuse		Use code above: _____ Or specify if other: _____
2		☐ Yes ☐ No ☐ Don't Know ☐ Refuse		Use code above: _____ Or specify if other: _____
3		☐ Yes ☐ No ☐ Don't Know ☐ Refuse		Use code above: _____ Or specify if other: _____
4		☐ Yes ☐ No ☐ Don't Know ☐ Refuse		Use code above: _____ Or specify if other: _____

[81] This question has been adapted from the Pact-MEASURE Evaluation OVC Questionnaire for Primary Caregivers.

***Healthy** (continued): HIV Disclosure*

	78	79	80
	Child's Name	**If the caregiver said the child is HIV positive: Has the child's status been shared with the child?**	**If yes: What was child's response?** ***Use following codes to answer below:** The child had a positive or neutral reaction (1); The child experienced denial, but is ok now (2); The child became angry, sad or depressed, but is ok now (3); The child is still dealing with denial, anger, sadness or depression (4); Other, specify (5)*	**If no: Why was the status not shared with the child?** ***Use following codes to answer below:** Child is too young; (1); Worried about the child experiencing stigma (2); Worried about the child having a negative response (3); Worried about the parent/family experiencing stigma (4); Other, specify (5)*
1		☐ Yes ☐ No	Use code above: ___ Or specify if other: _____	Use code above: ___ Or specify if other: _____
2		☐ Yes ☐ No	Use code above: ___ Or specify if other: _____	Use code above: ___ Or specify if other: _____
3		☐ Yes ☐ No	Use code above: ___ Or specify if other: _____	Use code above: ___ Or specify if other: _____
4		☐ Yes ☐ No	Use code above: ___ Or specify if other: _____	Use code above: ___ Or specify if other: _____

	81	82	83
	Child's Name	**If the caregiver said the child is HIV-positive: Has the status of the child been disclosed to any family members?**	**If yes: How did family members respond?** ***Use following codes to answer below:** Encouraging (want to help) (1); Neutral/no reaction (2); Rejected the child (3); Other, specify (4)*	If reaction was encouraging: Please share the name of this person and her/his relationship to the child.
1		☐ Yes ☐ No	Use code above: ___ Or specify if other: _____	Name: _____ Relationship: _____
2		☐ Yes ☐ No	Use code above: ___ Or specify if other: _____	Name: _____ Relationship: _____
3		☐ Yes ☐ No	Use code above: ___ Or specify if other: _____	Name: _____ Relationship: _____
4		☐ Yes ☐ No	Use code above: ___ Or specify if other: _____	Name: _____ Relationship: _____

DOMAIN: SAFE					
		84	85	86	87
	Child's Name	Does [name of child] have a birth certificate? If yes, ask to see it.	**Would you say that it is true that if [name of child] expresses a caring need (e.g., is hungry, wet, tired or upset/sad/scared), he/she can depend on you to respond and meet this need?**	**If no, why? For example, are you too tired, too busy or too sick?** Caseworker: Please observe as well. Do your observations support the response given? If so, refer to parenting skills training.	**Would you say it is true that you engage with [name of child] by telling stories, singing, playing games, listening to the child's stories, talking about school, friends and life?[82]**
1		☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No
2		☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No
3		☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No
4		☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No

		88	89	90
	Child's Name	Please observe as well. Do your observations support the response given?	**Recognizing the importance of relationships and connections, who else would you say [name of child] is close to? For example, is there a grandparent, sibling or another adult in the household who enjoys playing with the child?**	How often does this child play with other friends and family members?
1		☐ Yes ☐ No		☐ All the time ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
2		☐ Yes ☐ No		☐ All the time ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
3		☐ Yes ☐ No		☐ All the time ☐ Often ☐ Sometimes ☐ Rarely ☐ Never
4		☐ Yes ☐ No		☐ All the time ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

[82] Ibid.

		91	92	93	94
	Child's Name	**Sometimes adults beat/slap/spank or hit children. Has anyone ever beaten/ slapped/spanked [name of child], or hit [name of child] with a belt, a stick or something hard?[83] If you don't want to tell me, that is all right.**	**If yes, how often has someone beaten/ slapped/spanked [name of child], or hit [name of child] with a belt, a stick or something hard?[84]** ***Caseworker:*** *If almost every day, refer to statutory services. If once in a while or long time ago, refer to parenting.*	**If yes, was the child ever left with bruises, burns, broken bones or teeth, or other injury?** *Caseworker: If Yes, refer to statutory services.*	**If yes, did [name of child] receive or is [name of child] currently receiving services to help with this problem?**
1		☐ Yes ☐ No ☐ Refuse	☐ Almost every day ☐ Once in a while ☐ Long time ago ☐ Refuse	☐ Yes ☐ No ☐ Refuse	☐ Yes ☐ No If yes, from whom? _____
2		☐ Yes ☐ No ☐ Refuse	☐ Almost every day ☐ Once in a while ☐ Long time ago ☐ Refuse	☐ Yes ☐ No ☐ Refuse	☐ Yes ☐ No If yes, from whom? _____
3		☐ Yes ☐ No ☐ Refuse	☐ Almost every day ☐ Once in a while ☐ Long time ago ☐ Refuse	☐ Yes ☐ No ☐ Refuse	☐ Yes ☐ No If yes, from whom? _____
4		☐ Yes ☐ No ☐ Refuse	☐ Almost every day ☐ Once in a while ☐ Long time ago ☐ Refuse	☐ Yes ☐ No ☐ Refuse	☐ Yes ☐ No If yes, from whom? _____

		95	96	97
	Child's Name	**Has [name of child] ever been touched inappropriately or forced to do something against her/his will? If you don't want to tell me, that is all right.**	**If yes, did [name of child] receive or is [name of child] currently receiving services to help with this problem?** Caseworker: If no, refer to statutory services.	**Is there someone in the household or neighbourhood who is or has behaved inappropriately with the child? For example, has anyone made comments or shared content of a sexual nature, or asked or forced the child to do something sexual?**
1		☐ Yes ☐ No ☐ Refuse	☐ Yes ☐ No If yes, from whom? _____	☐ Yes ☐ No
2		☐ Yes ☐ No ☐ Refuse	☐ Yes ☐ No If yes, from whom? _____	☐ Yes ☐ No
3		☐ Yes ☐ No ☐ Refuse	☐ Yes ☐ No If yes, from whom? _____	☐ Yes ☐ No
4		☐ Yes ☐ No ☐ Refuse	☐ Yes ☐ No If yes, from whom? _____	☐ Yes ☐ No

[83] Ibid.
[84] Ibid.

GOAL SETTING

Caseworker: *"Now I'm going to ask you some questions about how you would like to see you and your household grow and improve over the next year."*

Over the next year, what would you like to work to accomplish? For example, would you like to learn more about how to improve your relationship with your children? Please create at least two goals, making sure that they are specific, measurable and have a timeline. For example: By ……(time), I will have ……(action).	**What actions need to take place for you to accomplish these goals?**

	Goal	Actions to accomplish Goal
1		
2		
3		
4		

Over the next year, what would you like to work with your child to accomplish? For example, would you like for [child's name] to work toward regularly attending school? Goals should be specific, measurable and achievable within a one-year time frame: By ……(time), I will have ……(action).	**What actions need to take place for you to accomplish these goals?**

	Child's Name	Goal 1	Goal 2	Actions to accomplish Goal 1	Actions to accomplish Goal 2
1					
2					
3					
4					

ANNEX 16: Tool: Well-being Assessment for Adolescents Ages 10 to 17

Note about bold and circled questions:

- Any questions that have **circles** relate to graduation benchmarks.
- Any questions that are **bolded** are considered essential questions and should not be removed during any adaptation process.

Note to the caseworker: If any of the below questions may be answered based on the results of information collected during the identification and/or enrollment process, such as in the Household Vulnerability Prioritization Tool or other documents contained within the family's case file, the caseworker should use that information to complete those response. Question with a circle are connected to one or more graduation benchmarks.

DEMOGRAPHICS

Note: *Boys and girls ages 10 to 17 should respond to the following questions themselves with consent from their caregivers.*

Caseworker reads: *"I'm going to begin by asking you some basic questions about yourself."*

1	**Record child's unique identifier code**	
2	**Record name of child**	
3	**Date of assessment**	
4	**Record/confirm child's sex**	☐ Male ☐ Female
5	**How old are you? If child does not know, ask caregiver to estimate age of child**	_____ years
6	**What is your birth date?**	_____ / _____ / _____
7	**Who takes care of you?[85] Anyone else?**	☐ Mother and/or father ☐ Sister and/or brother ☐ Aunt and/or uncle ☐ Grandmother and/or grandfather ☐ Other relative ☐ Neighbor ☐ Friend ☐ No one/self ☐ Other: _____
8	**If applicable, record caregiver's unique identifier code.**	
9	**What is your role in the family? For example, do you cook, do housework or make items, such as clothes or tools? Do you sell in the market or work outside of the household? Do you take care of other family members?**	

[85] This question was adapted from the Pact-MEASURE Evaluation OVC Questionnaire for Primary Caregivers.

	Question	Response	Action for Service Provision
	DOMAIN: SCHOOLED		
10	**Are you currently enrolled in school or a vocation program? If yes, which one?**	☐ Yes: School ☐ Yes: Vocational Training ☐ Not enrolled in either	*If not enrolled in either, enroll in either school or vocational training.*
11	**If neither, have you ever been enrolled in school?** **If no, why not?**	☐ Yes ☐ No _____ _____	
12	**If [name of child] is enrolled in school: What grade/ form/year are you in now?** **What grade/form/year were you in last year?**	_____ grade/form/year _____ grade/form/year	*If the child is not progressing in school, follow up to understand why not and in the case plan include action steps for addressing this.*
13	**If the child is enrolled in vocational training: What are you being trained in?** **When will you graduate from the vocational training program?**	_____ _____ / _____ / _____	
14	**During the last month, did you miss more than three school or training days for any reason?** **If yes, why?**	☐ Yes ☐ No _____ _____	
15	Do you like going to school or vocational training? If not, why?	☐ Yes ☐ No ☐ Fear of the teacher ☐ Fear of the other children ☐ Feeling lonely ☐ Bored ☐ Other (please specify): _____ _____	
	DOMAIN: STABLE		
16	**In the past month have you ever gone a whole day or night without eating anything at all because there was not enough food?** **If yes: How often would you say this happens?**	☐ Yes ☐ No ☐ Every night ☐ A few nights per week ☐ A few nights per month	*If yes, refer for nutritional support.*

	DOMAIN: HEALTHY		
17	**In the last month, have you gone more than three days when you were too sick or too tired to participate in daily activities?**	☐ Yes ☐ No	*If yes, refer for health services.*
18	**The last time that you were sick, were you taken to the doctor or the hospital?**	☐ Yes ☐ No	
19	Did someone tell you what you had? ☐ Yes ☐ No If yes, what was it? _____ Did you receive medication for this illness? ☐ Yes ☐ No If yes, what kind? _____		
20	**Do you have a disability or chronic illness that you would like to share with me? If yes, list response.** ☐ Yes ☐ No _____ **Are you currently receiving treatment for your illness or disability? If yes, from whom?** ☐ Yes ☐ No _____		*If the child has a disability or illness and is not receiving treatment, refer for health services.*
21	If you are often sick, have you been tested to know the cause of your illness? If yes, do you know the name of that test?	☐ Yes ☐ No _____	
22	**Have you ever heard talk of HIV? If yes, where did you hear about HIV? For example, school, friends, family, or church?**	☐ Yes ☐ No _____	
23	**Have you ever been tested for HIV?** ☐ Yes ☐ No **Do you know the results of your test?** ☐ Yes ☐ No **If yes: Can you share the results of the test with me?** ☐ Positive ☐ Negative ☐ Indeterminate ☐ Don't know ☐ Refuse *Caseworker: Thank you so much for sharing this.*		
24	**How did you find out about your HIV status?** ☐ Father ☐ Sibling ☐ Friend ☐ Teacher ☐ Other adult in the family ☐ Other, please specify: _____ How old were you the first time you heard this news? _____ years		
25	**Do you take medication for HIV?** ☐ Yes ☐ No If yes, do you like taking your treatment? ☐ Yes ☐ No If no, can you explain why you don't like taking your treatment? _____		*If no, refer for HIV services.*

26	**Which health facility do you visit?**	_____	
27	**Who in your household or your life knows about your HIV status?**	☐ Mother ☐ Father ☐ Other caregiver ☐ Sibling ☐ Teacher ☐ Friend ☐ Neighbor ☐Other, please specify: _____	
28	If at least one person knows status: What is that person's attitude toward you? Who are the members of your household that have an encouraging attitude toward you and help you?	_____ _____ _____	
29	Do you know anyone that is living with HIV?	☐ Yes ☐ No	
	DOMAIN: SAFE		
30	Would you say it is true that your caregiver listens when you talk to him/her?[86]	☐ All the time ☐ Often ☐ Sometimes ☐ Rarely ☐ Never	*If other than all the time or often, refer caregiver to parenting skills training.*
31	Would you say it is true that you can go to your caregiver for help and advice with problems and he/she will help to solve them?[87]	☐ All the time ☐ Often ☐ Sometimes ☐ Rarely ☐ Never	*If other than all the time or often, refer parent to parenting skills training.*
32	Do you feel like your opinions about you and your life are heard?	☐ Yes ☐ No	
33	When things get tough, do you feel that you can cope? If no, why not?	☐ Yes ☐ No _____	
34	Do you have friends that are older than you? If yes, do they ever buy or give you things? Do you feel pressure to do anything in exchange for these things?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	*If yes, refer child to teen group.*
35	*Sometimes adults beat / slap / spank or hit children*. Has anyone ever beaten / slapped / spanked you, or hit you with a belt, a stick or something hard?[88] If yes, how often has someone beaten/slapped/spanked you, or hit you with a belt, a stick or something hard?[89] *(continues in next page)*	☐ Yes ☐ No ☐ Refuse ☐ Almost every day ☐ Once in a while ☐ Long time ago ☐ Declined to answer	*If the child is experiencing violence, refer to statutory services.*

[86] Ibid.
[87] Ibid.
[88] Ibid.
[89] This question was adapted from the Pact-MEASURE Evaluation OVC Questionnaire for Primary Caregivers.

35	*(continues from previous page)* *Read alternatives* If yes, have you ever told someone about this? If yes, have you ever had to miss school because of it? If you have had to miss school because of the violence you experienced at home, did you receive or are your currently receiving any services to help with this problem? If yes, from whom?	☐ Yes ☐ No ☐ Refuse ☐ Yes ☐ No ☐ Refuse ☐ Yes ☐ No ☐ Refuse _____	*If the child is experiencing violence, refer to statutory services.*
36	Have you ever been touched by anyone on your body in a way you did not like or have you been forced to do something against your will?	☐ Yes ☐ No ☐ Refuse	
37	Has anyone in the household, neighbourhood, or school said things or asked you to do things that made you feel uncomfortable? For example, has anyone made inappropriate comments about your body, offered things in exchange, etc. If yes, did you receive or are you currently receiving any service or help with this problem? If yes, from whom?	☐ Yes ☐ No ☐ Refuse ☐ Yes ☐ No ☐ Refuse _____ _____	

GOALS

Caseworker reads: *"Now I'm going to ask you some questions about how you would like to grow and improve over the next year."*

Over the next year, what would you like to work to accomplish? For example, would you like to be enrolled in or to graduate from your vocational program? Please create at least two goals, making sure that they are specific, measurable and have a timeline. The time frame for the goals should be within the next year.	**Goal 1:** By _____ (time), I will have _____ (action). **Goal 2:** By _____ (time), I will have _____ (action).

Caseworker reads: *"What actions need to take place for you to accomplish these goals?"*

Goal 1	*Goal 2*

ANNEX 17: Tool: HIV Risk Assessment

Job Aid: The Caseworker should use an HIV Risk Assessment for children under the age of 18 years of age. The caseworker can fill in the assessment using information gathered through Household Vulnerability Prioritization Tool, assessment and any other forms used through the case management. Questions 1-8 have been left blank intentionally. The project or functional office should fill in these questions of risk suited to their context and in alignment with national guidelines. If information is missing, these questions should be asked in the follow-up visit to the family to complete the table below. This information should be reconfirmed every six months during a follow-up visit when the case plan is being updated.

HIV RISK ASSESSMENT PROTOTYPE FOR CASEWORKERS *For assessing children younger than 18 years of age.*		
Today's date: ____ / ____ / _____	Geographic ID:	Caseworker name:
Child name/ID:	Child age:	Caregiver name:

CURRENT HIV STATUS		
Does the caregiver know the status of the child?	**No**, the caregiver doesn't know the status.	Asses for HIV risk, **go to Q1**.
	Yes, the child is HIV+ ☐ HIV-positive	Use the **Antoretroviral Therapy (ART) Assessment**.
	Yes, the child is HIV- ☐ HIV-negative	Go to the next question.
Was the HIV test done less than 6 months ago?	**Yes**, the test was done less than 6 months ago.	**Stop.**
	No, the test was more than 6 months ago.	Asses for HIV risk, **go to Q1**.

HIV RISK ASSESSMENT			
Q1		☐ Yes ☐ No	☐ Yes ☐ No
Q2		☐ Yes ☐ No	☐ Yes ☐ No
Q3		☐ Yes ☐ No	☐ Yes ☐ No
Q4		☐ Yes ☐ No	☐ Yes ☐ No
Q5		☐ Yes ☐ No	☐ Yes ☐ No
Q6		☐ Yes ☐ No	☐ Yes ☐ No
Q7		☐ Yes ☐ No	☐ Yes ☐ No
Q8		☐ Yes ☐ No	☐ Yes ☐ No
Did the child have a **YES to at least one** of the above questions?	**YES, the child is at risk; HIV TEST REQUIRED**		☐ Continue
	NO, the child is not at risk; HIV TEST NOT REQUIRED		☐ Stop

PROGRESS MONITORING / UPDATING HIV STATUS *This section is used to track the progress of children who are at risk and require an HIV test.*		
Date: ___ / ___ / _____	Does the caregiver accept HIV testing for the child?	☐ Yes ☐ No
Date: ___ / ___ / _____	Was a formal referral made for HIV testing?	☐ Yes ☐ No
Date: ___ / ___ / _____	Was the referral to HIV testing completed?	☐ Yes ☐ No
If no, report why not: **If yes**, elicit the HIV test result of the child from the caregiver.		
Date: ___ / ___ / _____	☐ HIV-positive ☐ HIV-negative ☐ Unknown/undisclosed	
Date: ___ / ___ / _____	If HIV-positive, was the child referred for ART?	☐ Yes ☐ No
Date: ___ / ___ / _____	If HIV-positive, was the ART referral completed?	☐ Yes ☐ No
(If applicable) Record facility of child's enrollment:		

ANNEX 18: Tool: Case Plan Template

Instructions: Please use the information gathered from the Well-being Assessment Forms to help complete this form.

PLEASE NOTE THAT THE CASE PLAN FORM STAYS WITH THE CASEWORKER AND IS NOT LEFT AT THE HOUSEHOLD. IT MAY INCLUDE CONFIDENTIAL INFORMATION THE CHILD, ADOLESCENT OR ADULT DOES NOT WANT TO SHARE WITH THE REST OF THE FAMILY. DO NOT LEAVE THE CASE PLAN WITH THE CAREGIVER OR ANYONE IN THE HOUSEHOLD.

Date: _____ / _____ / _____ **Caseworker's name/contact information:** _____

Case manager staff name/contact information: _____

Name of caregiver: _____ **Name and age[s] of child[ren]:** _____

DOMAIN: HEALTHY					
GOALS OF HOUSEHOLD (this includes caregiver and child[ren])	**PRIORITY ACTIONS PERSON RESONSIBLE** *CAREGIVER*	**PRIORITY ACTIONS PERSON RESONSIBLE** *CHILD/CHILDREN* (include name[s] of child[ren])	**SERVICES TO BE PROVIDED AND / OR REFERRED TO**	**BY WHOM & DATE TO COMPLETE / CHECK WHEN COMPLETE**	**REMARKS**
			☐ HIV testing ☐ ART ☐ Viral load testing ☐ Other HIV and care treatment ☐ PMTCT/ANC ☐ HIV disclosure & counseling ☐ HIV peer support group ☐ Adolescent health counseling ☐ Other health services		

DOMAIN: STABLE					
GOALS OF HOUSEHOLD (this includes caregiver and child[ren])	**PRIORITY ACTIONS PERSON RESONSIBLE** *CAREGIVER*	**PRIORITY ACTIONS PERSON RESONSIBLE** *CHILD/CHILDREN* (include name[s] of child[ren])	**SERVICES TO BE PROVIDED AND / OR REFERRED TO**	**BY WHOM & DATE TO COMPLETE / CHECK WHEN COMPLETE**	**REMARKS**
			☐ Cash transfer ☐ SILC group ☐ Food support ☐ Nutritional assessment and supplements, etc.		

DOMAIN: SAFE					
GOALS OF HOUSEHOLD (this includes caregiver and child[ren])	**PRIORITY ACTIONS PERSON RESONSIBLE** *CAREGIVER*	**PRIORITY ACTIONS PERSON RESONSIBLE** *CHILD/CHILDREN* (include name[s] of child[ren])	**SERVICES TO BE PROVIDED AND / OR REFERRED TO**	**BY WHOM & DATE TO COMPLETE / CHECK WHEN COMPLETE**	**REMARKS**
			☐ Positive Parenting training ☐ Counseling ☐ Psychosocial support ☐ Health services, etc. ☐ Birth certificate ☐ Referral for GBV and/or other violence services		

DOMAIN: SCHOOLED					
GOALS OF HOUSEHOLD (this includes caregiver and child[ren])	**PRIORITY ACTIONS PERSON RESONSIBLE** *CAREGIVER*	**PRIORITY ACTIONS PERSON RESONSIBLE** *CHILD/CHILDREN* (include name[s] of child[ren])	**SERVICES TO BE PROVIDED AND / OR REFERRED TO**	**BY WHOM & DATE TO COMPLETE / CHECK WHEN COMPLETE**	**REMARKS**
			☐ School bursary ☐ Enrollment in school ☐ Enrollment in vocational training		

CASEWORKER ACTION POINTS

NOTE: List any emergency actions or referrals (malnutrition, ART default or child protection issues) that were made between the time of assessment and case planning or need to be made now.

REFERRALS: IDENTIFY THE SERVICES TO WHICH THE HOUSEHOLD AND/OR CHILD[REN] NEED REFERRAL.

List the individuals and/or organizations the caseworker needs to contact to implement the actions identified using the directory of services

Person to be referred: _____

Service: _____

Person to contact: _____

Person to be referred: _____

Service: _____

Person to contact: _____

Person to be referred: _____

Service: _____

Person to contact: _____

Person to be referred: _____

Service: _____

Person to contact: _____

AGREED UPON BY _____

PLEASE NOTE ON THE FOLLOWING PAGE A SUMMARY OF THE KEY PRIORITY ACTIONS TO SHARE WITH THE CAREGIVER. DO NOT INCLUDE ANY CONFIDENTIAL INFORMATION THE CHILD, ADOLESCENT OR ADULT DOES NOT WANT TO SHARE WITH THE REST OF THE FAMILY.

ANNEX 19: Tool: Summary of Key Priority Actions to Share with the Household

THIS FORM SHOULD BE LEFT WITH THE CAREGIVER.

Date: _____ / _____ / _____ **Unique identifier of the household:** _____

Caseworker's name/contact information: _____

Case manager staff name/contact information: _____

GOALS CAREGIVER & CHILD[REN]	PRIORITY ACTIONS *CAREGIVER*	PRIORITY ACTIONS *CHILD/CHILDREN* *(include name[s] of child[ren])*	DATE
			_____ / _____ / _____
			_____ / _____ / _____
			_____ / _____ / _____
			_____ / _____ / _____
			_____ / _____ / _____
			_____ / _____ / _____
			_____ / _____ / _____
			_____ / _____ / _____

ANNEX 20: Tool: Service Referral Form

Instructions: The purpose of this form is to provide and track referrals made to other service providers. Sections A and B should be completed by the caseworker. Section C should be completed by the service provider receiving the referral.

SECTION A

Date when referral is made: _____ / _____ / _____

Name of referring organization (CSO): _____

Name of case manager: _____

Phone number/ email of case manager: _____

Name of caseworker: _____

Phone number of caseworker: _____

Organization receiving referral: _____

(Please be specific health center, HIV testing services, ART clinic, peer support group, government institutions: child protection office, legal office, birth registration, etc. See SOP for more information.)

How urgent is this referral? ☐ Emergency ☐ Urgent ☐ Routine/Follow-up

Reason for referral: _____

_____

SECTION B

Name of person being referred: _____

Age: _____ years **Sex:** ☐ Male ☐ Female **Unique identifier code:** _____

Address: _____

Phone number: _____

_____ _____

Signature of person referring *Signature or thumbprint of child OR caregiver*

SECTION C

Date when service is received: _____ / _____ / _____

Service received: _____

Service provider contact information: _____

Comments: _____

_____

_____

_____

_____

ANNEX 21: Job Aid: What is Viral Load and How to Discuss it

Children, adolescents (age 10 years and older) and caregivers should be able to discuss their treatment regimens in relation to the following questions:

- *How many pills do you take per day?*
- *How many days did you miss taking your pills?*
- *What is the name of your medication?*
- *When was your last appointment at the health facility? When is your next appointment?*
- *What does viral load mean, and do you know your own viral load status (not number specific, but rather if it is high or low)?*
- *Do you have a treatment buddy?*

WHAT IS HIV?

An orphan and vulnerable children (OVC) project targets children, adolescents and their families who are affected by or living with HIV. **HIV stands for human immunodeficiency virus**. HIV is a virus (illness) that attacks a person's immune system cells and makes it difficult for the body to fight off infections. There is no cure for HIV, but there is treatment. **When a child or adult adheres to the treatment, the symptoms of HIV can be dramatically reduced and that person can live a normal life**. If a person with HIV does not take his/her medications, HIV will damage that person's immune system and the body's ability to fight off infections. HIV will then progress to the final stage of the illness: acquired immune deficiency syndrome (AIDS).[90]

HOW IS HIV TREATED?

It is extremely important that a child, adolescent or adult who has tested positive for HIV receives and stays on treatment. The treatment for HIV is called antiretroviral therapy (ART). This is a combination of three or more drugs used to treat HIV and prevent it from copying itself and spreading throughout the body. These medications keep the virus at low levels and improve the immune system. ART can keep children, adolescents and adults healthy, and help them lead normal, fulfilling lives with HIV. A healthcare professional is responsible for determining and giving guidance on matching the right type of treatment for a person. This is dependent upon age and existing health conditions.[91]

WHAT IS VIRAL LOAD?

One way that you can determine if the medication is doing what it should be doing, and if the child, adolescent or adult is taking the medication, is by **measuring the viral load**. The **viral load** shows how much HIV is in the body by measuring how many particles of HIV are in a blood sample. Viral load is described as being high or low. **The goal of HIV treatment and of OVC support is to help a child, adolescent or caregiver have a low viral load.**

The best-case scenario is for a person to have an **undetectable viral load. This can also be described as virally suppressed.** Virally suppressed means that a person living with HIV has adhered to ART on a regular basis and taken his/her medication, and that the treatment has decreased the level of virus in that person's body to such low levels that blood tests can no longer detect it. **If treatment is adhered to and viral load remains undetectable (as monitored by a health professional), a person cannot transmit HIV to others,**

[90] Retrieved from: *https://www.avert.org/about-hiv-aids/glossary*
[91] AVERT. Antiretroviral treatment for children living with HIV. Retrieved from: *https://www.avert.org/living-with-hiv/treatment-children*

and that person's health is not affected by HIV. This is recognized as a very important moment in the life of an HIV-positive person. **However, even when a person is virally suppressed, she/he must still take the medication.** In an OVC program, a child, adolescent or caregiver living positively needs to be on **treatment at least 12 months** to address some of the challenges associated with adhering to ART before being considered for successful exit from the OVC program.

ANNEX 22: Job Aid: Key Messages for Caseworkers

This job aid provides guidance on key messages to support caseworkers as they counsel and educate children living with and/or affected by HIV and their families during the case management process.

Counseling and educating on the four OVC domains (healthy, safe, stable and schooled) are central to effectively support children and families throughout the case management process, and should be carried out during each contact with the family, beginning at identification and continuing through enrollment, assessment, case plan development, and implementation, including referrals, monitoring and closure. For example, even during the closure process, it is imperative to reaffirm critical information and counsel families to ensure they know where to go and who to contact if they encounter any issues.

The caseworker should select and adapt the messages that are most relevant to their clients' needs, considering the stage of the case management process. These messages are organized across key OVC domains: healthy, safe, stable and schooled. They are based on validated guidance and/or curricula. Each case management form includes a reference to these key messages to ensure caseworkers are reminded to prepare for the next visit and utilize the appropriate message.

SPECIFIC TOPIC	LOCATION IN GUIDE
Healthy	
Promoting HIV testing for children and caregivers	A.1.
Importance of HIV treatment and adherence for viral load suppression	A.2.
Supporting disclosure to children	A.3.
Living positively with HIV and reducing stigma	A.4.
Promoting basic health and immunizations for children	A.5.
Infant health and PMTCT (early infant diagnosis, breastfeeding)	A.6.
Nutrition	A.7.
Safe	
Types of violence and their impacts on children	B.1.
Identifying and knowing where to report violence	B.2.
Children's knowledge about how to protect themselves, especially adolescent girls	B.3.
Importance of psychosocial support for children and caregivers	B.4.
Promoting parent-child and parent-adolescent relationships, improving parenting skills, and increasing parent problem-solving	B.5.
Stable	
Saving as a path to stability	C.1.
Setting financial goals	C.2.
Budgeting for families and children	C.3
Schooled	
Healthy early childhood development and learning	D.1.
Importance of education and parents'/caregivers' roles	D.2.

SECTION A | HEALTHY DOMAIN

A1. PROMOTING HIV TESTING FOR CHILDREN AND CAREGIVERS

- Testing infants and children while they are very young is lifesaving. Without treatment, more than half of infants and young children with HIV will die before reaching their second birthday.[92] However, starting treatment early is very effective and is the best way to keep children healthy.[93]
- Testing positive for HIV is not a death sentence. In fact, it is the opposite. Testing is what will allow babies and children to get lifesaving treatment if they need it. With treatment, infants and children can grow up to live healthy and normal lives. Testing is the first step.[94] If your child tests positive, he/she will be put on medication that will keep him/her healthy and ensure that he/she will grow up just like other children.
- Being tested is also important for you and your family to stay healthy. Just as testing is lifesaving for infants and young children who have been exposed to HIV, testing is also important and lifesaving for adults, adolescents and older children. Any person who may have been exposed to HIV should be tested. It can save your life, and the life of your children. The HIV Risk Assessment will help us determine if you should be tested. If a test is recommended, you will be provided with counseling and an HIV test. If your test is positive, you will be provided with treatment and the support you need to stay healthy. Testing is a very healthy step you can take for yourself and for your family.

***Note to caseworker:** use Tool: HIV Risk Assessment (Annex 17).

***Note to caseworker:** following the administration of the HIV Risk Assessment tool, make referral for testing if needed, and ask if the caregiver would like to be accompanied to the visit**.**

A2. IMPORTANCE OF HIV TREATMENT AND ADHERENCE FOR VIRAL LOAD SUPPRESSION

- You may wonder how antiretroviral therapy (ART) works and why it is so important to ensure that you and/or your child take the medication exactly as instructed, without missing doses.[95]
- The goal of ART is to reduce the amount of HIV in the blood and to increase the number of healthy immune cells (CD4 cells) in the blood as much as possible.[96]
- ART improves the quality of your life and/or the life of the child by:
  - Helping prevent the progression of HIV to AIDS;
  - Helping reduce the harm caused to the immune system by HIV;
  - Providing the immune system with a chance to recover from the harm caused by HIV;
  - Helping to reduce the number of opportunistic infections in adults and children living with HIV.[97]

[92] Newell, M. L., Coovadia, H., Cortina-Borja, M., Rollins, N., Gaillard, P. & Dabis, F. (2004). Mortality of infected and uninfected infants born to HIV-infected mothers in Africa: A pooled analysis. The Lancet, 364(9441), 1236–1243. *https://doi.org/10.1016/s0140-6736(04)17140-7*

[93] HHS Panel on Antiretroviral Therapy and Medical Management of Children Infected with HIV – A Working Group of the Office of AIDS Research Advisory Council (OARAC). Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. Available at: *http://aidsinfo.nih.gov/contentfiles/lvguidelines/pediatricguidelines.pdf*

[94] Thurman, T. R., Luckett, B., Taylor, T., & Carnay, M. (2016). Promoting uptake of child HIV testing: an evaluation of the role of a home visiting program for orphans and vulnerable children in South Africa. AIDS Care, 28(sup2), 7–13. *https://doi.org/10.1080/09540121.2016.1176679*

[95] SAfAIDS (2009). Supporting Parents and Caregivers of Children Living with HIV. Regional Children's HIV Treatment Literacy Toolkit. Retrieved from: *https://www.k4health.org/sites/default/files/TOT.Handbook.ART_.Toolkit.pdf*

[96] *Ibid.*

[97] *Ibid.*

- The only way to ensure that ART is as effective as possible is to be very regular and committed to adherence. The more you and/or the child take the medication exactly as instructed, without missing doses, the healthier you and/or the child will be because the amount of HIV in the body will stay low. This is called viral load. If a dose is missed or treatment stops, the amount of HIV in the body – the viral load – will increase. Keeping viral load low by taking treatment exactly as instructed, every dose, is the way that you and/or your child will stay healthy.[98]
- It is not always easy to ensure that your child takes medication exactly as instructed without missing doses. You can get support to help ensure medication is taken by talking with your child's doctor and to members of a caregiver support group.
- We can also add actions to your case plan to help. Are there any actions you would like to add, such as asking your doctor for help, or talking to other caregivers in your caregiver support group?

***Note to caseworker:** the caregiver may need a referral to a caregiver support group. Offer to provide a referral and to accompany them to the first session.

A3. SUPPORTING DISCLOSURE TO CHILDREN

- Gradually informing children or adolescents about their HIV status in a supportive and caring way is a healthy step, and it is called disclosure.[99] There are many benefits of disclosure that you may be interested to know about:
  - Timely disclosure from a primary caregiver to a young person can improve relationships, communication and trust.
  - Open and honest communication encourages love, care and confidence – making all the challenges of being positive easier to deal with.
  - Young people who know their HIV status are better able to tell those who need to know – teachers, carers and relationship partners. This builds a stronger circle of care.
  - Young people who know their HIV status also enjoy increased access to support services in their communities, and are more likely to join support groups and access professional counseling services, which keeps them healthier and happier.[100]
- Disclosure is a process. It does not have to happen all at once, and it may require support.[101] For different reasons, many caregivers are worried about disclosing status for the first time.[102] This is understandable, and there are resources to help with disclosure if you need support. Would you be interested in a referral to a professional who can help you and your child with disclosure?"
- If yes: provide referral to: **[note to program: update with referral information from directory of services].**

***Note to caseworker:** ask if the caregiver would like to be accompanied to the visit.

- If no: "That is ok, disclosure is a process. There are often signs that your child may be ready for disclosure. Signs can be if he/she asks questions about his/her medication, health or development, why other children don't take

[98] *Ibid.*

[99] Krauss, B., Letteney, S., Baets, A. de, Murugi, J., Okero, F. A. & World Health Organization (n.d.). Guideline on HIV Disclosure Counselling for Children up to 12 Years of Age. Retrieved from: *http://whqlibdoc.who.int/publications/2011/9789241502863_eng.pdf*

[100] Oblinger, D. G. (2012). Let's Talk Disclosure: Your Disclosure Support Guide for Tackling Tough Topics, Together. SAfAIDS and Oxfam. Retrieved from: *https://catalogue.safaids.net/sites/default/files/publications/Oxfam%20Disclosure%20Booklet%20(Reprint)_Final%20(Web)_0.pdf.*

[101] Aderomilehin, O., Hanciles-Amu, A. & Ozoya, O. O. (2016). Perspectives and Practice of HIV Disclosure to Children and Adolescents by Health-Care Providers and Caregivers in sub-Saharan Africa: A Systematic Review. Frontiers in Public Health. Retrieved from: *https://doi.org/10.3389/fpubh.2016.00166*

[102] *Ibid.*

medication. Other signs include any questions about being teased, asked about HIV status, or if your child shows she/he wants to understand more about her/his status.[103] When you are ready for help with this, I will help you with a referral. I will also ask again in our next visit if you are ready. Do you think you would like a referral now?"

- If yes: provide referral to: **[note to program: update with referral information from directory of services]**. Ask if the caregiver would like to be accompanied to the visit.
- If no: remark in case plan as action to offer disclosure referral again in next visit.

A4. LIVING POSITIVELY WITH HIV AND REDUCING STIGMA

A person who is living with HIV can have a normal, productive and healthy life. Practicing Positive Living helps you stay healthy and happy. The same behaviors that are important for living a healthy and positive live in general are even more important to help you live positively with HIV. Some of the things that help are staying active, getting enough sleep and rest, eating a balanced diet, staying away from alcohol and drugs, and getting help from your support system. These behaviors, when combined with adherence to your treatment, will help you have a normal, productive, and healthy life.[104]

***Note to caseworker:** choose one or more of the following messages to reinforce Positive Living with HIV.

- **Staying active**: Staying active makes you feel happier, helps you sleep better, increases your appetite, and reduces stress. Activity also keeps your body strong so it can fight the disease and allow you to carry on with your day-to-day activities.[105]
- **Adequate sleep and rest**: Although each person is different, it is important for all people living with HIV to get plenty of rest to fight illness and remain healthy. When you are tired, your body can become weak so you are more likely to get sick. Try to sleep eight hours each night so that you can feel strong during the day. Always rest when you feel tired so that your body can become strong again.[106]
- **Nutrition**: A balanced diet gives you strength, energy and protection from illnesses. When you are taking medication, your body needs extra nutrients and minerals. A healthy diet can make your HIV treatment more effective. A complete balanced diet includes body-building foods, such as meat, beans, peas, fish, and eggs; energy-giving foods, such as rice, ***papa*** **[update with locally relevant word]**, bread and potatoes; and protective foods like fruits and vegetables.[107]
- **Alcohol and drugs**: Alcohol and drugs make your immune system weaker, which allows HIV to multiply in your body. They can weaken your body by making it harder to get vitamins and minerals from the food you eat. Abusing alcohol and drugs also makes your medicine less effective, which can make side effects worse. When you use alcohol and drugs, it's also harder to remember to live positively.[108]
- **Support system**: A support system allows you to share your worries and relieve stress. You can learn about ways to cope with your HIV status and manage your symptoms and treatment. In a support group, members can also share how they overcame some of the same challenges you might be facing. Remember, you are not alone; there are people in your community, workplace, church or health facility who can help and support you.[109]

[103] Vaz, L. M. E., Eng, E., Maman, S., Tshikandu, T. & Behets, F. (2010). Telling Children They Have HIV: Lessons Learned from Findings of a Qualitative Study in Sub-Saharan Africa. AIDS Patient Care and STDs, 24(4), 247–256. *https://www.liebertpub.com/doi/abs/10.1089/apc.2009.0217*

[104] Johns Hopkins University Center for Communication Programs (2013). Living Positively with HIV: Healthy Mind and Healthy Body. Retrieved from: *http://ccp.jhu.edu/documents/Living Positvely with HIV… Healthy Mind and Healthy Body_1.pdf*

[105] *Ibid.*

[106] *Ibid.*

[107] *Ibid.*

[108] *Ibid.*

[109] *Ibid.*

A5. PROMOTING BASIC HEALTH AND IMMUNIZATIONS FOR CHILDREN

There are a few things that all children and caregivers can do to stay healthy.

- **Practice good hygiene:** Practicing good hygiene will help you and your child avoid illnesses. One way of the best ways to do this is by washing your hands with soap and water. Be sure to wash your hands with soap and water before preparing foods and feedings your baby and after using the toilet or cleaning a child's bottom.[110]
- **Use clean water:** Use clean water to take medications, drink, and prepare food. Ensuring that water is clean may require boiling the water or treating with chorine. Containers used to store water should have a tight lid to prevent insects or other animals from contaminating the water. The containers used to store water should regularly be washed with soap and water inside and out.[111]

There are also a few things that caregivers should know about keeping their children healthy.

- **During the first year of life:** Enjoy watching your child grow and remember to attend monthly growth monitoring and promotion sessions. During these sessions you can ask questions about your child's growth, health and nutrition and also learn about when your child should begin receiving immunizations. Immunizations protect babies against many diseases.[112]
- **When your child is sick:** It is important to also know when your child is sick and should be taken to the health facility. If your child: 1) refuses to eat and is weak, 2) is vomiting, breathing fast or appears malnourished, or 3) has diarrhea or a fever, you should immediately take your child to a health facility.[113]

A6. INFANT HEALTH AND PMTCT (EARLY INFANT DIAGNOSIS, BREASTFEEDING)

***Note to caseworker:** select the message below that is most appropriate for the mother based on whether she is living with HIV and is pregnant, or if she has an infant who is less than six months old.

For women who are living with HIV and are pregnant: While it is possible for a woman living with HIV to pass the disease to the baby during pregnancy, labor, delivery or through breastfeeding, this does not mean that all babies born to HIV-positive mothers will also have the disease. There are things that you can do to minimize this risk. First, it's critical that you receive antenatal care at your health facility while you are pregnant.[114] Have you visited your doctor since becoming pregnant?

- **If no, provide a referral to the health facility and explain:** While at the health facility you will learn about the importance of taking your antiretroviral treatment during pregnancy and breastfeeding. Taking your medication as directed by doctor will weaken the disease in your body and make it less likely that HIV will pass to your child. Also, while you are at the clinic you will learn about how to breastfeed your baby. Exclusively breastfeeding your baby for the first six months will help your baby become strong and reduces the risk that the child will become sick due to illnesses such as diarrhea, pneumonia or HIV.[115]

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[110] Spring Nutrition (n.d.). Community infant and young child feeding counselling package: Key messages booklet (Nigeria). Retrieved from *https://www.spring-nutrition.org/sites/default/files/training_materials/files/c-iycf_key_messages_nigeria.pdf*

[111] Republic of Zambia Ministry of Health (2017). Nutrition care and support for people with HIV: Training manual for community volunteers. Retrieved from: *https://www.fantaproject.org/sites/default/files/resources/Zambia-Community-NACS-Training-FACILITATOR-Guide-2017.pdf*

[112] *Ibid.*

[113] *Ibid.*

[114] UNICEF (2012). The community infant and young child feeding counselling package. Retrieved from: *https://www.unicef.org/nutrition/files/Key_Message_Booklet_2012_small.pdf*

[115] World Health Organization (2018a). Infant feeding for the prevention of mother-to-child transmission of HIV. Retrieved from: *http://www.who.int/elena/titles/hiv_infant_feeding/en/*

- **If yes, state:** This is a good thing that you have done for your family. When you visited the clinic did you discuss with the doctor the importance of taking your antiretroviral treatment during pregnancy and breastfeeding? This will reduce the likelihood that you will pass HIV to your child. Did you also discuss breastfeeding for the first six months? Exclusively breastfeeding your baby for the first six months will help your baby become strong and reduces the risk that the child will become sick due to illnesses such as diarrhea, pneumonia or HIV.[116]

For women who are living with HIV and have an infant less than six months old: Congratulations on the birth of your new child! How are you and the child? Have you visited the health clinic since the birth?

- **If no, provide a referral to the health facility and explain:** It is important to visit the health clinic, even if your baby looks healthy, to check that HIV has not been passed to the child.[117] To prevent passing HIV to your baby, it is important that you continue to take your antiretroviral treatment as directed by your doctor, and that you practice exclusive breastfeeding. Breastfeeding is best for babies because it helps them become strong and reduces the likelihood that they will become sick due to illnesses such as diarrhea, phenomena or HIV.[118]

***Note to caseworker:** see Section A7. Nutrition for key messages on nutrition and for more information on nutrition for babies under six months of age.

- **If yes, ask:** Has your baby been tested for HIV?
  - **If no, provide a referral to the health facility and explain:** Tests should first be done when the child is six weeks old. Knowing the child's HIV status will allow doctors to provide the necessary treatment to help the child grow up healthy and strong. Something that you can do now to help your child be strong is to continue to take your antiretroviral treatment and to exclusively breastfeed for the first six months. Exclusive breastfeeding reduces the risk that the child will become sick due to illnesses such as diarrhea, phenomena or HIV.[119]
  - **If yes, explain:** It is good that you have done a test. Until the child is 18 months old, doctors will need to check the child's HIV status. As your baby grows, it's important to exclusively breastfeed for **at least** the first six months to help the child strong and to reduce the risk that they will become sick due to illnesses such as diarrhea, phenomena or HIV.[120]

A7. NUTRITION

***Note to program manager:** all messages need to be reviewed and aligned with national guidelines.

***Note to caseworker:** select the message below that is most appropriate for the caregiver or child depending on age, pregnancy, HIV status and services available in the community and through the referral network.

In order for children to develop to their full potential, good nutrition is required to ensure adequate growth and psychological functioning in the first two years of life.[121]

[116] *Ibid.*
[117] World Health Organization (2018b). Care of the HIV exposed or infected newborn. Retrieved from: *http://www.who.int/maternal_child_adolescent/newborns/care_of_hiv_exposed/en/*
[118] World Health Organization (2018a). Infant feeding for the prevention of mother-to-child transmission of HIV. Retrieved from: *http://www.who.int/elena/titles/hiv_infant_feeding/en/*
[119] *Ibid.*
[120] *Ibid.*
[121] Daniels, M.C., Adair, L.S. (2004). Growth in young Filipino children predicts schooling trajectories through high school. J Nutr. 2004; 134:1439–46; Grantham-McGregor S., Cheung Y.B., Cueto S., Glewwe P., Richter L., and Strupp B. (2007). International Child Development Steering Group. Developmental potential in the first 5 years for children in developing countries. Lancet. 2007; 369(9555):60–70; Walker, S.P., Chang, S.M., Powell, C.A. Simonoff, E., Grantham-McGregor, S.M. (2007). Early Childhood Stunting Is Associated with Poor Psychological Functioning in Late Adolescence and Effects Are Reduced by Psychosocial Stimulation. American Society for Nutrition J. Nutr. 137:2464-2469, November 2007.

- **For all household members:** Good nutrition is important for everyone, but especially pregnant and lactating women, children under five years old and people living with HIV and TB. Good nutrition helps the body stay strong, develop, grow and fight infection. You can maintain good nutrition by eating a variety of foods from different food groups in the correct amounts. This gives the body the energy and nutrients it needs for good health.[122]
- **For all household members:** Good hygiene and sanitation are also important for the health of all family members. One of the most important things everyone in the family should do is wash their hands with soap or ash regularly. These are the critical times for handwashing: before eating, before cooking, after using the latrine, after cleaning a baby's or an adult's bottom, after cleaning the latrine/potty, and before and after taking care of a sick person.[123] It is also important to make sure that the food and water you consume is safe. You can do this by preparing, cooking and storing food properly and by using water that is clean and has been boiled, filtered or treated with chlorine. It is also important for everyone in the household to be dewormed regularly.[124]
- **For pregnant women/adolescent girls:** Congratulations on your pregnancy! To make sure that you stay healthy and that your baby grows and develops properly, it is important to eat the proper amount and right kinds of foods. It is also important for women to supplement their diets with iron and folic acid. During your pregnancy, it is very important to go to the health facility at least four times, receive a tetanus toxoid vaccination, and to deliver your baby there with a trained birth attendant. During your visit, the nurse or midwife ***[adapt names based on local context]*** will check to make sure that you and the baby are both healthy. You will also be counseled about the right kinds and amounts of food to eat, as well as the importance of taking iron and folic acid supplements, Vitamin A supplementation, sleeping under a mosquito net, and being treated for malaria quickly. Have you visited the health facility yet for this pregnancy?[125]
  - **If no, provide a referral to the health facility and explain:** Visiting the health facility during pregnancy is very important for your health and the health of the baby. Why haven't you been able to go? **[Note to caseworker: listen for barriers such as money for transport, consultation, taking care of children, permission from husband, etc.]** What do you think we could do to address this problem?
  - **If yes, say:** I am glad to hear you went to the health facility. Did the health facility staff provide you with nutritional counseling? **[Note to caseworker: listen for confirmation of increased intake of energy and protein foods and receipt of iron and folic acid tablets.[126]]** You can also get nutrition information from the community health worker or by attending an infant and young child feeding (IYCF) support group. They can give you more information about nutrition during pregnancy and for your newborn baby and during the first 24 months of your child's life. I'd like to refer you to them. Is that okay?
    - Follow up with: While you were at the health facility, did you get an HIV test and receive the results?
    - **If no,** provide a referral to the health facility for HIV testing and see A6.
  - **If no, provide a referral to a community health worker and/or IYCF support group and explain:** It is good to hear that you went to the health facility, but making sure you have the right information about the foods you need is important. I would like to refer you to the community health worker and the infant and young child feeding group in this community. They have special training to know what pregnant women, their newborn infants and very young children need to eat and how to prepare it. Can I provide you with a referral?

[122] Zambia Ministry of Health, National Food and Nutrition Commission and Food and Nutrition Technical Assistance III Project (FANTA) (2017). Nutrition Assessment, Counselling and Support (NACS) Training Manual for Community Volunteers: Facilitators' Guide. Lusaka, Zambia: National Food and Nutrition Comission.

[123] *http://hip.fhi360.org/file/27033/CC1%20-%20Critical%20Times%20for%20Handwashing.pdf*

[124] Nutrition Assessment, Counseling, and Support (NACS) Slides for Training Facility-based Service Providers.

[125] World Health Organization (2016). WHO Recommendation on Antenatal care for positive pregnancy experience. Geneva: World Health Organization.

[126] Guyon, A. & Quinn, V. (2011). Booklet on Key Essential Nutrition Action Messages. Washington, D.C.: Core Group.

- **For lactating women/adolescent girls and children less than 6 months:** Congratulations on the birth of your new baby! What is his/her name? How old is he/she? For the health of the mother and baby, it is important to give only breast milk to the baby until they are six months old. When I say only breast milk I mean no water, tea or any other food. If the infant gets sick, it is still important to feed him/her only breast milk. I know giving breast milk only can sometimes be difficult. Are you having any difficulties that prevent you from giving only breast milk to the baby?[127]
  - **If yes, provide a referral to the community health worker and infant and young child feeding support group and say:** I know, breastfeeding can be very difficult. I am going to refer you to the community health worker for assistance. I would also recommend that you join the infant and young child feeding support group where you can learn more about the nutrition and other needs of your baby.
  - **If no, provide a referral to the infant and young feeding support group and say:** It is good for your health and the baby's that you are only giving breast milk; that is not easy. I'm going to refer you to the infant and young feeding support group where you can start to learn what your baby will need as he/she gets older and needs to be weaned.
- **For caregivers of all children 6-59 months:** After six months, it is important to introduce new foods to your baby. It is also important to take them for regular growth monitoring and ensure they are getting immunized on time. Do you attend an infant and young child feeding support group?
  - **If yes, say:** It is good that you attend the support group. Are there any behaviors they have discussed that you are having difficulty with?
  - **If yes, ask:** How do you think we could address that challenge?
  - **If no, provide a referral to an infant and young child feeding support group and/or community health worker and say:** To help you learn how to prepare the right kinds of food for your child, I'd like to refer you to the IYCF support group and/or the community health worker.
  - **Ask:** Do you have a growth monitoring card for [insert name of child[ren] under 59 months]? May I see it please?
  - **If most recent mark is in the green zone, say:** It looks like [insert name] is growing well. You are doing a good job. Just remember if [insert name] becomes malnourished, experiences a fever, fast breathing, convulsions, diarrhea or vomiting or will not eat, you need to take him/her to the health facility immediately.[128]
  - **If most recent mark is in the yellow or red zone, ask**: Since this measurement was recorded have you visited the health facility again?
  - **If yes, ask:** What did they recommend? **[Listen for recommended food products, receipt of** ready-to-use **therapeutic foods.] Ask:** When is your next follow-up visit? Are you able to follow their recommendations?
    - **If yes, say:** I'm glad to hear you are following their recommendations. For those who may have received ready to use therapeutic food (RUTF) as a treatment for undernutrition remind the caregiver not to share the RUTF with other family members.
    - **If not able to follow recommendations, say:** What recommendations are you having difficulty with? **[Note to caseworker: listen to client and if insufficient food is available, provide a referral to social protection, household economic-strengthening and/or food-security/support services.]**

[127] *Ibid.*

[128] Federal Ministry of Health of Nigeria with UNICEF, WHO, USAID, PEPFAR and the SPRING Project (2012). The Community Infant and Young Child Feeding Counselling Package: Key Messages Booklet. Abuja, Nigeria.

Caseworkers trained to conduct nutritional screening using mid-upper arm circumference (MUAC) tape for children 6-59 months and under: I would like to use this tape to measure [insert name of child] arm.

- **If child's MUAC measurements indicate underweight or Moderate Acute Malnutrition (in yellow zone of the tape) or Severe Acute Malnutrition (in red zone):** Based on my measurement, [insert name of child] is malnourished. I would like to provide you with a referral to take him/her to the health facility for treatment and Nutritional Assessment Counseling and Support.[129]

- **For adults/adolescents living with HIV:** People living with HIV or TB need more nutritious food (more calories) to stay healthy. Also, to be effective, certain medicines may need to be taken with food, while others need to be taken on an empty stomach. It is also important for people with chronic illnesses like HIV to be weighed regularly and to record this weight. This is important for two reasons: 1) being too light or too heavy is not healthy, and 2) unexplained weight change can be a sign that something is wrong. Have you experienced changes in your weight recently?[130]
  - **If yes, provide a referral to the health facility and say:** It is important that you are monitoring your weight, and there can be many reasons for an unexplained change in weight. I would like to refer you to the health facility to receive a nutritional assessment, counseling and support, also called NACS.
  - **If no changes in weight, say:** I am glad to hear you have not had a change in your weight recently, but I would like to know if you have received a nutritional assessment, counseling and support, also called NACS, at the health facility? Did you get a NACS action plan to follow?
  - **If yes, ask:** What recommendations did you receive from the health facility? **Or:** What is included in your NACS action plan? [Listen to the recommendations.] **Ask:** Are you having any difficulties following these recommendations? [Listen for challenges.] **If client says he/she does not have enough food to eat, provide referral to social protection, household economic-strengthening and/or food-security/support services.**
  - **If no difficulties, say:** I am glad to hear you are able to follow the instructions from the doctor/nurse. It is important to keep taking your medicine as prescribed to remain healthy and productive. It is also very important to regularly wash your hands with soap, and keep your appointments at the health facility so they can monitor your weight and provide other important services.[131]
- **For caregivers of children living with HIV:** To maintain their health and grow, children with HIV need to eat nutritious foods from different food groups, maintain good personal hygiene, eat nutritious food, and drink clean water. They also need to take their medicines every day as prescribed by the doctor, and receive regular growth monitoring to make sure they are gaining weight and growing well. During your visit to the health facility, have you received nutritional assessment, counseling and support?
  - **If yes, say:** I'm glad to hear that. What did they recommend? Did you make a NACS action plan? Are you having any challenges implementing this plan? [Listen to client's response.] **If client says he/she does not have enough food to feed the child, provide referral to social protection, household economic-strengthening and/or food-security/support services, ask:** What can we do to address these challenges?
  - **If no, provide a referral to the health facility and say:** Children with HIV have special nutritional needs, and they change over time. It is very important that you know about the right amounts and kinds of foods [insert name] needs to be healthy. I would like to refer you and [insert name] to the health facility for nutritional assessment, counseling and support.[132]

[129] Zambia Ministry of Health, National Food and Nutrition Commission and Food and Nutrition Technical Assistance III Project (FANTA) (2017). Nutrition Assessment, Counselling and Support (NACS) Training Manual for Community Volunteers: Facilitators' Guide. Lusaka, Zambia: National Food and Nutrition Commission.

[130] Nutrition Assessment, Counseling, and Support (NACS) Slides for Training Facility-based Service Providers.

[131] *Ibid.*

[132] Nutrition Assessment, Counseling, and Support (NACS) Slides for Training Facility-based Service Providers.

SECTION B – SAFE DOMAIN

B1. TYPES OF VIOLENCE AND THEIR IMPACTS ON CHILDREN

Causes of violence are complex and sometimes caregivers themselves experienced violence as children. They may not know other ways to cope, especially when stressed, but it is possible to get support and learn other ways to cope and to manage children's behavior.

- Sometimes the stress of being a caregiver is so heavy that it makes it hard to be a calm parent. This is true for a lot of parents, and it is possible to get support. Being part of a support group and learning positive techniques to deal with stress and manage children's behaviors is often helpful. Do you think you might be interested in such a program? Improved communication skills and conflict resolution help reduce violence in the household.[133]

***Note to caseworker:** note the need for a parenting intervention in case plan and refer for parenting. If, however, there is concern about the safety of the child[ren] or he/she is seen to be in imminent danger, refer to your supervisor and the appropriate services immediately.

- **Violence can be physical, emotional and/or sexual.**
- There are many types of violence. Violence can be physical; for example, hitting, kicking or causing bodily harm to a child. Violence can also be emotional, for instance, insults and name-calling or discriminating (treating someone differently) so that the child is made to feel worthless or less valued/deserving than other family members. Abuse and violence can also be sexual. This means that a child is touched, forced to do something, or exposed to sexually explicit behavior. Sexual abuse, or any abuse, is **NEVER** the fault of the child.

***Note to caseworker:** if you suspect or it is reported to you that there is any kind of violence or abuse in the household, you must immediately report this to the appropriate authorities and to your direct supervisor.

- **Both boys and girls can be physically, emotionally and/or sexually abused.**
- Abuse can happen to both boys and girls, even sexual abuse. Men and women can also perpetrate violence or be abusive. Children of all ages can be victims of all types of abuse. It is therefore important to talk to your children about how they can protect themselves and how they can talk about any abuse with a trusted adult.

***Note to caseworker:** if you suspect or it is reported to you that there is any kind of violence or abuse in the household, you must immediately report this to the appropriate authorities and to your direct supervisor.

- **Children with disabilities can also be abused, physically, emotionally or sexually.**[134]
- Girls and boys with disabilities are often abused. It is sometimes hard for them to tell people because of a disability, or because we think that they are safe. We have to take extra care in ensuring that children who have a disability are protected, including from sexual abuse.

***Note to caseworker:** if you suspect or it is reported to you that there is any kind of violence or abuse in the household, you must immediately report this to the appropriate authorities and to your direct supervisor.

- **Most violence, including sexual violence, is carried out by people we know.**

[133] Richter, Linda M. and Sara Naicker (2013). A review of published literature on supporting and strengthening child-caregiver relationships (parenting). Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

[134] Groce, N.E., Rohleder, P., Henning Eide, A., MacLachlan, M., Mall, S. & Swartz, L. (2013). HIV issues and people with disabilities: A review and agenda for research. Social Science & Medicine 77 (2013) 31e40.

- Although it is hard to understand, in many cases, those who are supposed to protect children, like parents, teachers or family members, are the ones perpetrating the abuse. As a parent it is important to know with which adults your children are engaging. It is also important that you talk to your children about how they can protect themselves, and that they should always talk to a trusted adult if they don't feel they are safe. Children have a good sense of intuition, and often have a feeling inside that tells them when they are not safe. As parents we need to encourage this, and reassure our children that they should trust their own feelings, and if anything happens that they should always tell someone.
- **The impact of violence is not always visible. Children don't always talk about it because they are afraid.**
  - Physical signs on the outside of the body are not the only signs that a child is being abused or violated. Sometimes it is difficult to know if a child is being hurt; often, the child doesn't want to talk about it, and there may not be obvious physical signs on the body. Sometimes a child is afraid to say anything because she/he mistakenly believes it is her/his fault. All of these are reasons that we need to be aware and look for signs.
  - Some signs that a child might be abused include changes in the daily routine, not wanting to go to school or church/mosque or to a relative's house, and/or sadness or a change in usual personality. Have you noticed changes in your child's behavior?
  - If yes, when did this begin? Have you talked to anyone about it? If you are concerned, then we should probably talk to the child. There are people who are trained to do this.
  - If you are unsure, I will to talk to my supervisor about this and he/she will help us determine what we should do to make sure that if your child is being harmed, we get him/her the help he/she needs and deserves.
- **Trauma and continuous high stress will impact brain development. If a child is physically, sexually or emotionally abused, it impacts not only a child's well-being, but can also harm his/her development, including how brain development.**[135]
- Any kind of abuse is harmful to children. However, it is not just the body that is hurt, long-term stress can impact a child's development. As parents we want our child[ren] to be healthy and free from harm, so it is very important that if we suspect abuse, we report it immediately. We want to intervene and stop the abuse and help our children heal as soon as possible.

***Note to caseworker:** if you suspect or it is reported to you that there is any kind of violence or abuse in the household, you must immediately report this to the appropriate authorities and to your direct supervisor.

- **Violence against women also increases the risk of violence against children in the household.**[136]

B2. IDENTIFYING AND KNOWING WHERE TO REPORT VIOLENCE

- **If you or your child suffer from violence (physical, sexual or emotional) you should tell someone you trust.**
- This could be a friend or neighbor or relative or someone from your church/mosque or support group. You can also talk to me if you and/or your child[ren] are being hurt. I can make a referral to a place that will help you.
- If you or your child suffer from violence (physical, sexual or emotional) you or someone else should report it to the authorities (police, Department of Children's Services or child protection committee). They are trained to help you.

[135] National Scientific Council on the Developing Child (2012). The Science of Neglect: The Persistent Absence of Responsive Care Disrupts the Developing Brain: Working Paper 12. http://www.developingchild.harvard.edu

[136] Guedes, A., Bott, S., Garcia-Moreno, C. and Colombini, M. (2016). Bridging the gaps: a global review of intersections of violence against women and violence against children. Global Health Action. *www.globalhealthaction.net*

***Note to caseworker:** if there appears to be abuse in the household, please emphasize that you can tell someone whose job it is to help. Ask the caregiver if she/he would like to talk to you or to share information. If the response is yes, please be sure to provide a referral to the appropriate service, i.e., health and/or legal services (the health facility, police and/or child protection service). Follow the instructions in the SOP for reporting abuse.

- **If your child or adolescent is being sexually abused, you must take them to the health clinic immediately.**
- Sexual abuse includes any kind of touching, forcible sex or someone making you do or watch something sexual. Sexual abuse of children is especially harmful, and has serious health repercussions, including pregnancy, physical injury and HIV.
- Are you and/or your child[ren] being sexually abused? If yes, I would like to refer you to a special health clinic so that we can get you and/or your child[ren] the services you need.

B3. CHILDREN'S KNOWLEDGE ABOUT HOW TO PROTECT THEMSELVES, ESPECIALLY ADOLESCENT GIRLS

- **Adolescent girls are more vulnerable to sexual abuse and exploitation, which increases their risk of getting HIV.**

Adolescent girls are more vulnerable to sexual abuse and exploitation in some situations. Older men may buy them things or pay for school in exchange for sex. This is still abuse, and is dangerous for the child as she can contract HIV, experience bodily harm, and/or become pregnant.

- **It is important to speak to your children about how they can protect themselves, and encourage them to tell you if they sense they are unsafe or if they are being abused in any way.**[137]
- If your son/daughter has been sexually abused, the first thing you need to do is to comfort him/her.
- The second thing you need to do is to reassure your child that it is not her/his fault. No child or adolescent ever asks for or deserves to be abused. Abuse is never the child's/adolescent's fault. Part of helping your child heal and keeping her/him protected is reassuring them of this.
- The next thing to do is to tell someone you trust and report the abuse. There are people and organizations that are trained to deal with these things.
- Do you have concerns that your son or daughter is being sexually abused? If yes, it is my job to help you and your child get the services and help you need.
- If the caregiver does not respond now, remind him/her that you are always available to talk to and that they should trust you with the information.

***Note to caseworker:** if there appears to be abuse in the household, please emphasize that you can tell someone whose job it is to help. Ask the caregiver if she/he would like to talk to you or to share information. If the response is yes, please be sure to provide a referral to the appropriate service, i.e., health and/or legal services (the health facility, police and/or child protection service). Follow the instructions in the SOP for reporting abuse.

B4. THE IMPORTANCE OF PSYCHOSOCIAL SUPPORT FOR CHILDREN AND CAREGIVERS

- Having someone in whom you can confide or with whom you can talk – someone that you trust – is very important. This can be a friend, neighbor priest/imam or relative.[138]
  - A support system allows you to share your worries and relieve stress. Remember, you are not alone; there are people in your community, workplace, church or health facility who can help and support you.[139] It is very important for you and your children to have people in your lives who you trust and who can help you in times of difficulty.

[137] Ismayilova, L., Ssewamala, F.M. & Karimli, L. (2011). Family support as a mediator of change in sexual risk-taking attitudes among orphaned adolescents in rural Uganda. Journal of Adolescent Health 50, 228-35.
[138] Skovdal, M. & Onyango Ogutu V. (2012). Coping with hardship through friendship: the importance of peer social capital among children affected by HIV in Kenya. African Journal of AIDS Research 11(3):241-50.
[139] *Ibid.*

- In many situations, having someone you can talk to, someone that you trust and turn to in difficult times, has been shown to help families get through difficult times and stay together. [140, 141]
- Parents who feel that they have support (friend, neighbor, extended family or faith community) are better able to deal with stress and parent their children in a positive manner.[142]

***Note to caseworker:** if it becomes apparent that the caregiver does not have external support, please make a referral to an HIV support group, parenting class, community women's group and/or a faith-based organization that might be able to provide psychosocial support.

B5. PROMOTING PARENT-CHILD AND PARENT-ADOLESCENT RELATIONSHIPS, IMPROVING PARENTING SKILLS AND INCREASING PARENT PROBLEM-SOLVING

- A positive relationship with your child and the way that you parent impacts your child's development, health, behavior, emotions and relationships with others for their whole lives.[143]
- Being involved in your child's life, interacting with your child in ways that support him/her (for example, listening to him/her, asking about school, etc.), and heading off problems before they arise helps the child to be strong and better able to handle difficulties in life.[144]
- When adults, including parents, ignore a child's needs, yell, hit or use other physical punishment, push a child away (physically and emotionally), or try to control every situation, this can result negatively impact a child's health, development and relationships throughout his/her entire life.[145]

***Note to caseworker:** if there appears to be abuse in the household, please emphasize that you can tell someone whose job it is to help. Ask the caregiver if she/he would like to talk to you or to share information. If the response is yes, please be sure to provide a referral to the appropriate service, i.e., health and/or legal services (health facility, police and/or child protection service). Follow the instructions in the SOP for reporting abuse.

- Good communication with your children helps them to solve problems and be strong when they face challenges, this can also help them to stay healthy and avoid HIV and other risks.[146] Good communication can also lead to a more peaceful home.[147]
- Knowing about your child's development (i.e., what your child is able to do or not do at a certain age or stage of life) gives you more understanding regarding how to protect them from challenges and risks that arise,[148] and will help you feel more confident about raising them.[149]

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[140] Betancourt, T., Meyers-Ohki, S., Stulac, S., Barrera, A. E., Mushashi, C., Beardslee, W.R. (2011). Nothing can defeat combined hands (Abashize hamwe ntakibananira): Protective processes and resilience in Rwandan children and families affected by HIV and AIDS Social Science & Medicine 73, 693-701

[141] Cluver, L., Bowes, L. & Gardner, F. (2010). Risk and protective factors for bullying victimization among AIDS-affected and vulnerable children in South Africa. Child Abuse & Neglect 34:793–803

[142] *Ibid.*

[143] Collins, W., Maccoby, E., Steinberg, L., Hetherington, E. & Bornstein, M. (2000). Contemporary research on parenting: The case for nature and nurture. American Psychologist, 55, 218-232.

[144] Centers for Disease Control (2013). Preventing Maltreatment through the Promotion of Safe, Stable and Nurturing Relationships Between Children and Caregivers. Retrieved from: *https://www.cdc.gov/ViolencePrevention/pdf/CM_Strategic_Direction--Long-a.pdf*

[145] Al-Hassan, S. & Lansford, J. (2010). Evaluation of the Better Parenting Programme in Jordan. Early Child Development and Care, 1-12; O'Connor, T. & Scott, S. (2007). Parenting and Outcomes for Children. In D. Utting, Parenting and the Different Ways it Can Affect Children's Lives. York: Joseph Rountree Foundation.

[146] Oates, J. (2010). Early Childhood in Focus: Parenting. London, UK: Open University, and Fundudis, T. (1997). Single Parents: Risk or resilience? Child Psychiatry and Psychology Review, Vol 2, 2-14.

[147] A review of published literature on supporting and strengthening child-caregiver relationships (parenting). Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1. Retrieved from: *https://aidsfree.usaid.gov/sites/default/files/aidstarone_parenting_litreview_finalweb.pdf*

[148] *Ibid.*

[149] *Ibid.*

- Parenting programs and information about positive parenting can help you build stronger relationships with your children and learn effective communication skills and positive discipline strategies. Parenting programs also provide opportunities for parents/caregivers to practice new skills.[150]

***Note to caseworker:** note the need for a parenting intervention in case plan and refer for parenting intervention.

SECTION C – STABLE DOMAIN

- Parents who feel that they have the resources (social, financial, etc.) to meet their family's needs or know where to access services are better able to manage stress and positively engage with their children, including proactive problem solving, good communication and positive relationships.[151]

C1. SAVING AS A PATH TO STABILITY

- **Saving is a powerful tool to build economic stability.** Anyone can start to save, even if it is just a little bit. Starting a habit of saving, even a small amount, will help you gain more control over your finances.
- **As you save more, your savings will help you in many ways:**
  - You can save for future goals, such as saving to pay for school fees at school enrollment period, to buy school supplies, or to invest in a business, or you can save to be financially ready for an anticipated event or recurring health costs, such as giving birth or chronic medical needs.
  - Your savings can help you be prepared for shocks or unexpected expenses. If there is an emergency, such as an unanticipated sickness, you will have savings to help you cover the expenses.
  - Savings can prevent you from having to take out expensive loans. If you can use your savings, you will not be forced to pay someone very high fees to borrow money when you need it.
- **There are safe community options to help you save that will protect your money.**
  - Many communities have safe community savings groups that you can join with other people to safely save money.
  - These groups may be called SILC, VSLA, ISLA or another name.
  - These are groups of people who trust each other and have decided to save together. Group members save the amount that they decide, and after an agreed-upon period of time, members receive their money back, plus earnings on their investment.
  - Members also have the option to take loans (borrow money) from these groups, to invest in businesses, schooling or other activities.
  - Members of these groups meet regularly to save and discuss other important topics.
  - These groups become an important source of financial and social support for members.
  - Members of these groups often help each other in emergencies.
  - Are you interested in learning more about a group such as this?

***Note to caseworker:** note in case plan and refer to SILC or another savings group. During follow-up visit ask the caregiver if she/he has decided to join SILC or another savings group, and note response in case plan.

[150] *Ibid.*

[151] Centers for Disease Control (2013). Preventing Maltreatment through the Promotion of Safe, Stable, and Nurturing Relationships Between Children and Caregivers. Retrieved from: *https://www.cdc.gov/ViolencePrevention/pdf/CM_Strategic_Direction--Long-a.pdf*

C2. SETTING FINANCIAL GOALS

- **Goals are what you want to achieve (your vision) in the future.** Financial goals are decisions about how you want to spend your money over a specific period of time. These goals help you to spend your money wisely, limit unnecessary spending, and increase your savings by setting clear goals for how you want to use your money in the future.
- **Financial goals need to be SMART – Specific, Measurable, Achievable, Realistic and Timebound.** Let's look at this in more detail**. Specific goals** are defined target and value goals. **Measurable goals** include milestones to measure progress. **Achievable goals** ensure that the steps or milestones to reach the goals are in place. **Realistic goals** take into consideration and can be achieved with your available resources. A goal should be **timebound** with a target date for completion**.**
- It is important to establish short-, medium- and long-term financial goals. **Short-term is one to two months, medium-term is one to two years, and long-term is more than two years.**
- **An example of a SMART medium-term goal** is to save 24,000 shillings by next September to pay school fees and to pay for school supplies and uniforms for two children. Since it is January now, there are nine months to save for this financial goal. Each month I know I earn enough income that I can I save **3,000 shillings in my SILC**. This means I should reach my goal in August when SILC share-out happens, which will ensure I am ready to pay school fees in September.
- Let's take some time to talk about a few **short-, medium- and long-term financial goals.** What are your financial goals? Let the caregiver know that you will be asking about progress made toward the goals and any new goals during the next visit.
- Are you interested learning more about setting financial goals? **(Note to program manager: if financial education is not an available service, remove this prompt)**

***Note to caseworker:** note financial goals in case plan and refer for financial education. During the next visit, review the financial goals with the caregiver to ensure they are SMART. Ask the caregiver to list any additional financial goals she/he has identified since the last visit and note in the case plan. Ask the caregiver what steps have been taken to reach the financial goals.

C3. BUDGETING FOR FAMILIES AND CHILDREN

- **Having a budget gives you more control over your money so that you can reach your goals.** Many people do not know where their money goes. Money comes in and out of the household, but they are not keeping tracking of how much, when and what for. If you do not keep track of money coming in and out, you do not have very much control.
- **Learning to keep a budget does not have to be complicated.** A basic budget covers the money that comes into the household and the money that goes out of the household. The budget takes into account rich times and lean times. A budget can help you predict how much money you will need and when.
- **Having a basic budget can help you prioritize.** When you know how much you need and when, you can make smart choices. If you know that important expenses are coming up, you can say no to other expenses that are less important. Having a budget can help you make decisions about how you are going to reach your financial goals, such as saving for important needs, and for unforeseen emergencies.
- **A budget will allow you to make choices that are good for your children.** Most parents want to provide the best they can for their children, but often lack of money makes this hard. Having a budget will help you

distinguish between "needs" and "wants," and will help you to meet your financial goals and the needs of your children. When you know how much is needed for schooling, for example, and how much you have to spend on food, clothes, shelter and other needs, it is easier to plan for these needs, and to save for them over time. When you have a plan and are in control, it is easier to say no to things that are just "wants" and won't help you to reach your goals.

- **It doesn't matter how big or how small your income, every family benefits from having goals and establishing a budget.**
- **Are you interested in learning more about making and managing a budget? (Note to program manager: if financial education is not an available resource, remove this prompt.)**

***Note to caseworker:** note in case plan and refer for financial education. During the next visit the caseworker should ask if the caregiver has established a budget and what he/she has observed regarding the household's spending, savings and progress toward financial goals since establishing a budget.

SECTION D – SCHOOLED DOMAIN

D1. HEALTHY EARLY CHILDHOOD DEVELOPMENT AND LEARNING

- **Even babies and very young children are learning.** They learn through play and exploration. Supporting development is as important as antenatal care, breastfeeding, growth monitoring and immunizations.[152] Parents can provide simple activities and materials, and simply talk to their babies and respond to their verbal and nonverbal communication, to ensure their children's healthy development and acquisition of skills.[153] This helps children to be healthy, strong and ready for school when they are older.

***Note to caseworker:** babies of adolescent mothers are more vulnerable to poor development outcomes, these messages along with practice playing with baby can help young mothers become more confident and better able to support their baby's development.

- **Some babies are more at risk for having development and learning challenges.** This includes young children affected by HIV.[154] They have higher risks for mental and physical development problems during the first two years of life.[155] You can help by paying attention to their progress, learning about child development and milestones, and visiting clinic when you have questions. Be sure to tell me (caseworker) when you have questions.
- **Questions or problems regarding babies' and young children's development need to be identified and addressed as soon as they are noticed.** If not, any issues can become more severe as children get older.[156]

[152] Slemming, W., Saloojee, H. & Berry, L. (2013). Beyond survival: The role of health care in promoting ECD. South African Child Retrieved from: *http://ci.org.za/depts/ci/pubs/pdf/general/gauge2013/Gauge2013HealthServices.pdf*

[153] Tamis-LeMonda, C. (2001). Maternal responsiveness and children's achievement of language milestones. Child Development. Retrieved from: *http://onlinelibrary.wiley.com/doi/10.1111/1467-8624.00313/full* and Aboud, F., & Yousafzai, A. (2015). Global health and development in early childhood. Annual Review of Psychology. Retrieved from: *http://www.annualreviews.org/doi/abs/10.1146/annurev-psych-010814-015128*

[154] Boivin, M., Bangirana, P. & Nakasujja, N. (2013). A year-long caregiver training program improves cognition in preschool Ugandan children with human immunodeficiency virus. The Journal of Pediatrics. Retrieved from: *http://www.sciencedirect.com/science/article/pii/S0022347613008147* and Aboud, F. & Yousafzai, A. (2015). Global health and development in early childhood. Annual Review of Psychology. Retrieved from: *http://www.annualreviews.org/doi/abs/10.1146/annurev-psych-010814-015128*

[155] Potterton, J. (2008). A longitudinal study of neurodevelopmental delay in HIV infected children. Retrieved from: *http://wiredspace.wits.ac.za/handle/10539/5055* and Baillieu, N., & Potterton, J. (2008). The extent of delay of language, motor, and cognitive development in HIV-positive infants. Journal of Neurologic Physical Therapy. Retrieved from: *http://journals.lww.com/jnpt/Abstract/2008/09000/The_Extent_of_Delay_of_Language,_Motor,_and.3.aspx*

[156] Blanchette, N., Lou, M. & Fernandes-Penney, A. (2001). Cognitive and motor development in children with vertically transmitted HIV infection. Brain and Cognition. Retrieved from: *http://www.sciencedirect.com/science/article/pii/S0278262601800324*

You (the parent/caregiver) know your baby and child best – better than anyone! What you notice about your child is important for identifying early childhood development problems.[157]

***Note to caseworker:** note the need for early childhood education and/or development intervention in case plan and refer.

D2. THE IMPORTANCE OF EDUCATION AND PARENTS'/CAREGIVERS' ROLES

- **Education is one of our most important tools to protect boys and girls from acquiring HIV and help them live positive lives if they are living with HIV**. Evidence shows that staying in school has positive effects in preventing HIV infection. Young people with higher levels of education are more likely to take actions to protect themselves and avoid actions that put them at risk.[158] In addition, schooling is especially important for girls to empower them with tools that will empower them to protect themselves from risk throughout their lives.[159]
- **Ensuring that your daughter or son stays in school is one of the most important steps you can take to help them build healthy and productive lives.**

***Note to caseworker:** share the messages with the caregiver that are appropriate for the child's age.

- **As a caregiver, you can help your child by utilizing the age-appropriate suggestions below.**
  - **Primary school age:**[160]
    - Encourage play. Play is an important way for children to learn, even when they are old enough to attend school.
    - Allow your child to be creative. Children have many interesting ideas, and a creative attitude helps them learn.
    - Set clear rules at home and be consistent: establish a bedtime that ensures your child enough sleep to concentrate in school. Establish mealtimes so your child eats healthy food before school and before bed.
    - Encourage your child to attend school using praise and positive language.
    - If your child has homework, help him/her establish good habits. Ensure your child has a quiet space and time to focus. Provide your child with structure and encouragement.
    - Young children should spend only a little bit of time on homework, and more time on play. As they get older, children can spend more time on homework, but should still have time to play.
    - Congratulate your child for her/his efforts. A strong effort deserves praise!
    - If it is feasible, show or read books to your child.
    - Show excitement when your child tells you what she/he has learned in school. Ask questions that show you are interested.
    - Allow your child to talk about anything with you when he/she comes to school – likes, dislikes, fears and excitement. Thank your child for sharing with you.

[157] Regalado, M. & Halfon, N. (2001). Primary care services promoting optimal child development from birth to age 3 years: review of the literature. Archives of Pediatrics & Adolescent Medicine. Retrieved from: *http://archopht.jamanetwork.com/article.aspx?articleid=191309*

[158] UNICEF, Basic Education and Gender Equality – HIV and AIDS. Retrieved from: *https://www.unicef.org/education/index_focus_aids.html*

[159] Hargreaves, J. & Boler, T. (2006). The Impact of Girls' Education on HIV and Sexual Behavior. ActionAid International.

[160] Van Voorhis, F. L., Maier, M. F., Epstein, J. L. & Lloyd, C. M. (2013). The Impact of Family Involvement on the Education of Children Ages 3 to 8: A Focus on Literacy and Math Achievement Outcomes and Social-Emotional Skills. October, 1–199.

- **Secondary school age:**[161]
  - Encourage your child to continue to attend school regularly; use praise and positive language.
  - Continue to provide clear rules and be consistent: set expectations for your child that ensure regular meals, time for homework and adequate sleep.
  - Show an interest in your child's education – ask questions to show that you are interested in what is happening at school.
  - Congratulate your child for his/her efforts. A strong effort deserves praise!
  - Help your child find a quiet and well-lit place to do homework.
  - Help ensure that your child has time away from chores to complete homework.
  - You do not need to help your child with homework; just providing a child with structure and encouragement will have a very positive impact.
  - Help your child establish goals; talk to her/him about their hopes for their performance in school. Support them to work toward their goals.
  - Show your child that she/he can trust you to talk about problems she/he may experience at school – listen with an open mind and try to understand your child.

***Note to caseworker:** based on needs identified in needs assessment, note the need for education support in case plan and refer.

[161] Fear, J., Emerson, L., Fox, S., and Senders, E. (2012). Parental engagement in learning and schooling: Lessons from research. *https://doi.org/978-0-9872370-3-3*

ANNEX 23: Tool: Monitoring Form

To be used for subsequent visits to household after case plan has been developed. It is recommended that the case plan be reviewed at a minimum of every three months and actions updated. Updates to actions can be made in an updated case plan, or a home visit monitoring form.

Instructions: Please use the information gathered from the case plan or previous follow-up forms to help complete this form. Discuss the case plan with the family members, using the agreed-upon goals and actions outlined in the case plan to frame the conversation.

Date: _____ / _____ / _____

Caseworker's name/contact information: _____

Case manager name/contact information: _____

Name of caregiver: _____

Caregiver ID: _____

Names and ages of child[ren]: _____

_____

_____

Since our last visit, have there been any major positive and/or negative changes within your family that have affected you or the child[ren]? ☐ Yes ☐ No

If yes:

Positive changes: _____

_____

_____

Negative changes: _____

_____

_____

Has the size of your family changed since our last visit? ☐ Yes ☐ No

If yes, please list names and indicate child, adult and whether he/she has joined or left household.

Note: *If additional children have joined the household, please make sure to gather information on each child using the assessment form. If children have left the household, please make sure to get detailed information regarding why they left, where they have gone, and identify how best to follow up on these children either directly or through another organization if beyond the geographical scope of the program.*

Since our last visit, is there any other information you would like to share?

CASEWORKER ACTION POINTS

OTHER REFERRALS THE HOUSEHOLD AND/OR CHILD[REN] NEED FOLLOWING THE VISIT

List the individuals and/or organizations the caseworker needs to contact to implement the actions identified using the directory of services.

Person to be referred: _____	**Service:** _____	**Person to contact:** _____
Person to be referred: _____	**Service:** _____	**Person to contact:** _____
Person to be referred: _____	**Service:** _____	**Person to contact:** _____
Person to be referred: _____	**Service:** _____	**Person to contact:** _____

Date of next visit: _____ / _____ / _____	**Agreed by:**

PLEASE NOTE ANY UPDATES ON THE SUMMARY OF THE KEY PRIORITY ACTIONS ALREADY SHARED WITH THE CAREGIVER. DO NOT INCLUDE ANY CONFIDENTIAL INFORMATION THE CHILD, ADOLESCENT OR ADULT DOES NOT WANT TO SHARE WITH THE REST OF THE FAMILY.

ANNEX 24: Tool: Graduation Benchmarks Assessment Tool

Instructions for Graduation Benchmarks Assessment:

The caseworker should complete this form with each household to assess whether the household is ready to graduate from the program for orphans and vulnerable children (OVC). **Before meeting with the primary caregiver or other members of the household, the caseworker should first go through the questionnaire below and pre-fill it with information already gathered and available in the household's casefile.** Throughout the document, instructions to the caseworker are given in bold type. Caseworkers can also use a one-page scoring sheet (Appendix 1) to reduce printing costs.

All applicable benchmarks must be assessed for all children, adolescents, and youth in the household and all primary caregivers (maximum of two caregivers per child). For the household to graduate, all applicable benchmarks must be met for primary caregivers, all children and adolescents ages 0–17, and all youth ages 18–20 and still in secondary school.

The benchmarks apply to individuals and households as follows:

BENCHMARKS	BENEFICIARIES					HOUSEHOLDS
	ALL AGES	HIV+	10-17 YEARS	0-4 YEARS	SCHOOL AGE	
Known HIV status (or test not required)	✓					
Adherent / Virally suppressed		✓				
Knowledgeable about HIV prevention			✓			
Not malnourished				✓		
Financially stable						✓
No violence reported						✓
Not in a child-headed household						✓
Children in school					✓	

COVER SHEET

Date of assessment: _____ / _____ / _____ **Name of CBO:** _____

Name of caseworker conducting assessment: _____

Household (HH) ID: _____

Date HH enrolled in project: _____ / _____ / _____

Has HH been previously assessed for graduation? ☐ No ☐ Yes, on date(s) _____ / _____ / _____

Household address: _____

Primary Caregiver 1 ID: _____ **Primary Caregiver 2 ID:** _____

Primary Caregiver 1 Gender: ☐ Male ☐ Female **Primary Caregiver 2 Gender:** ☐ Male ☐ Female

Primary Caregiver 1 Age: _____ **Primary Caregiver 2 Age:** _____

Please list below all children and adolescents ages 0–17 years and all youth ages 18–20 years and still in secondary school that are living in the household.

#	FULL NAME OF CHILD, ADOLESCENT, OR YOUTH	AGE	GENDER (M/F)	UNIQUE ID	REGISTERED IN THIS OVC PROGRAM?
1					☐ Yes ☐ No
2					☐ Yes ☐ No
3					☐ Yes ☐ No
4					☐ Yes ☐ No
5					☐ Yes ☐ No
6					☐ Yes ☐ No
7					☐ Yes ☐ No
8					☐ Yes ☐ No

***Note**: If there are more than two primary caregivers or more than eight children, adolescents, or youth in the household, please attach additional Cover Sheets with data on additional members of the household. There may be up to two primary caregivers per child or adolescent.*

COVER SHEET (ADDITIONAL MEMBERS OF THE HH)

Date of assessment: _____ / _____ / _____ **Household ID:** _____

Name of caseworker conducting assessment: _____

Primary Caregiver 3 ID: _____ **Primary Caregiver 4 ID:** _____

Primary Caregiver 3 Gender: ☐ Male ☐ Female **Primary Caregiver 4 Gender:** ☐ Male ☐ Female

Primary Caregiver 3 Age: _____ **Primary Caregiver 4 Age:** _____

Please list below all children and adolescents ages 0–17 years and all youth ages 18–20 years and still in secondary school that are living in the household.

#	FULL NAME OF CHILD, ADOLESCENT, OR YOUTH	AGE	GENDER (M/F)	UNIQUE ID	REGISTERED IN THIS OVC PROGRAM?
9					☐ Yes ☐ No
10					☐ Yes ☐ No
11					☐ Yes ☐ No
12					☐ Yes ☐ No
13					☐ Yes ☐ No
14					☐ Yes ☐ No
15					☐ Yes ☐ No
16					☐ Yes ☐ No
17					☐ Yes ☐ No
18					☐ Yes ☐ No
19					☐ Yes ☐ No
20					☐ Yes ☐ No

***Note**: If there are more than two primary caregivers or more than eight children, adolescents, or youth in the household, please attach additional Cover Sheets with data on additional members of the household. There may be up to two primary caregivers per child or adolescent.*

BENCHMARK 1 (1.1.1): KNOWN HIV STATUS (OR TEST NOT REQUIRED)	
QUESTION	**RESPONSE**
Answer the following questions using the casefile: 1.1. Has each child, adolescent, and youth in the household been documented as "HIV status positive," "HIV status negative," or "test not required based on risk," according to an HIV risk assessment? 1.2. Has each primary caregiver in the household been documented as "HIV status positive," "HIV status negative," or "test not required based on risk," according to an HIV risk assessment?	☐ Yes ☐ No ☐ Yes ☐ No
Has Benchmark 1 been met? *If Questions 1.1 and 1.2 are answered "Yes", Benchmark 1 has been met.*	☐ **Yes** ☐ **No**

BENCHMARK 2 (1.2.1): VIRALLY SUPPRESSED	
QUESTION	**RESPONSE**
If there is no child, adolescent, youth, or primary caregiver in the household living with HIV, skip this section. Tick Not Applicable (N/A) and proceed to Benchmark 3. **Answer the following questions for each child, adolescent, youth, or primary caregiver in the household living with HIV, using additional pages if needed. Use Option (a) or (b) based on whether viral load testing results have been documented in the casefile.**	☐ N/A Beneficiary's ID:
Option (a): *Complete this section if viral load testing results are documented in the casefile. Answer the following question using the casefile.* 2.1. Has this beneficiary been documented as virally suppressed (<1,000 copies/mL) for the past 12 months?	☐ Yes ☐ No
Option (b): *Complete this section if viral load testing results are not documented in the casefile. Answer the following question using the casefile.* 2.2. In the past 12 months, has this beneficiary been regularly attending ART appointments and picking up ART pills on schedule? *This means that the casefile shows that at every monthly or quarterly visit in the past 12 months, the beneficiary was regularly attending ART appointments and picking up ART pills on schedule.* 2.3. In the past 12 months, has this beneficiary been taking antiretroviral therapy (ART) pills as prescribed? *This means that the casefile shows that at every monthly or quarterly visit in the past 12 months, the beneficiary was taking ART pills as prescribed.*	☐ Yes ☐ No ☐ Yes ☐ No
Has Benchmark 2 been met for this beneficiary? *Option (a): If Question 2.1 is answered "Yes", the beneficiary has met Benchmark 2.* *Option (b): If Questions 2.2 and 2.3 are answered "Yes", the beneficiary has met Benchmark 2.*	☐ **Yes** ☐ **No**

BENCHMARK 3 (1.3.1): KNOWLEDGEABLE ABOUT HIV PREVENTION

QUESTION	RESPONSE
If there is no adolescent ages 10–17 in the household, skip this section. Tick N/A and proceed to Benchmark 4. **Ask the following questions of <u>each</u> adolescent ages 10–17 in the household. Each adolescent should be interviewed separately in a private location where no one else can hear, and using a separate page.** **If the adolescent's statements are not clear, request more information by using probes such as, *"I am not sure I understand. Can you tell me more about that?"*** **Tick the box next to <u>each</u> item that the adolescent mentions. Do not read the list of HIV risks or HIV prevention strategies to the adolescent. His or her responses should be unprompted.**	☐ N/A Beneficiary's ID: _____
3.1. Can you tell me how a young person your age living in your community might become infected with HIV? **The adolescent must describe <u>two</u> risks to meet Benchmark 3. If he or she has described only <u>one</u> HIV risk listed below, ask, *"Can you tell me any other ways a young person in your community might become infected with HIV?"*** ☐ Early sex (starting sex young) ☐ Sex with an older partner ☐ Sex with a partner who has multiple partners ☐ Sex with multiple partners ☐ Sex without a condom ☐ Being sexually abused or raped ☐ Sex for money or gifts (transactional sex, having a "sugar daddy")	☐ Yes ☐ No
3.2. Can you tell me how a young person your age living in your community might help protect himself or herself from becoming infected with HIV? **The adolescent must describe <u>one</u> prevention strategy to meet Benchmark 3. If he or she has not described any of the strategies below, ask, *"Can you tell me any other ways a young person might help protect himself or herself against HIV?"*** ☐ Having one sexual partner ☐ Delaying sex or abstinence ☐ Having a sexual partner who is HIV negative ☐ Using a condom during sex ☐ Having a partner who does not have other sexual partners ☐ Not having sex for money or gifts, or transactional sex **This section involves open-ended questions that will require you to make a judgment regarding whether Benchmark 3 has been met.** **The criterion is that the adolescent demonstrates an understanding of HIV risk and prevention, not that he or she gives an answer matching the questionnaire word for word.**	☐ Yes ☐ No
Has Benchmark 3 been met for this beneficiary? *If Questions 3.1 <u>and</u> 3.2 are answered Yes, this beneficiary has met Benchmark 3.*	☐ **Yes** ☐ **No**

BENCHMARK 4 (1.4.1): NOT UNDERNOURISHED	
QUESTION	**RESPONSE**
If there are no children <5 years of age in the household, skip this section. Tick N/A and proceed to Benchmark 5. **For a child under the age of 6 months, do not assess the MUAC and bipedal edema. Visually assess any child under the age of 6 months. If the child looks undernourished according to your judgment, the child has not met Benchmark 4. The following assessment should be done for each child ages 6-59 months. Use additional pages if necessary.**	☐ N/A Child's ID: _____
Assess the child's MUAC and bipedal edema if you have been trained in how to conduct these assessments. If you have not received this training, request that the MUAC be measured by a health worker or caseworker who has been trained in assessing the MUAC and bipedal edema.	
4.1. Is the child's MUAC more than 12.5 cm?	☐ Yes ☐ No
4.2. Is the child free of any signs of bipedal edema?	☐ Yes ☐ No
Has Benchmark 4 been met for this beneficiary? *If Questions 4.1 and 4.2 are answered "Yes" (for a child ages 6-59 months), the child has met Benchmark 4.* *If a child under the age of 6 months looks undernourished according to your judgment, tick "No".*	☐ **Yes** ☐ **No**

BENCHMARK 5 (2.1.1): IMPROVED FINANCIAL STABILITY	
QUESTION	**RESPONSE**
The following questions should be asked of one primary caregiver as defined by the project. **Primary caregiver's ID:** _____	
5.1. Were you or another caregiver in the household able to pay school fees for the last school year for all children and adolescents in your household under the age of 18?	☐ Yes ☐ No
5.2. Were you able to pay these school fees without using a cash transfer, grant, or scholarship from [name of CBO or OVC project]?	☐ Yes ☐ No
5.3. Were you able to pay for these school fees without selling something used to generate income that you did not plan or want to sell, such as livestock, land for agriculture, tools, or equipment for a business?	☐ Yes ☐ No
5.4. Were you or another caregiver in the household able to pay all medical costs in the past 6 months for all children and adolescents in your household under the age of 18? Medical costs include medicine, clinic fees, and transport to medical appointments.	☐ Yes ☐ No
5.5. Were you able to pay for these medical costs without using a cash transfer or grant from [name of CBO or OVC project]?	☐ Yes ☐ No
5.6. Were you able to pay for these medical costs without selling something used to generate income that you did not plan or want to sell, such as livestock, land for agriculture, tools, or equipment for a business?	☐ Yes ☐ No
Has Benchmark 5 been met? *If Questions 5.1, 5.2, 5.3, 5.4, 5.5, and 5.6 are all answered "Yes", Benchmark 5 has been met.*	☐ **Yes** ☐ **No**

BENCHMARK 6 (3.1.1): NO VIOLENCE

QUESTION	RESPONSE
The following questions should be asked of a female primary caregiver (one primary caregiver only). **If there is only a male primary caregiver in the household, and there are no female primary caregivers, the male primary caregiver should be asked Questions 6.1, 6.2, and 6.3, but not Question 6.4.** **If there is any record or evidence that a member of the household has been referred to the police, child protection services, or another social services organization because of violence in the past six months, Benchmark 6 is not met. In this case, skip this section and proceed to Benchmark 7.** **Primary caregiver's ID:** _____	
Read to caregiver: *"Sometimes people, even children, experience violence or abuse in their households or other places outside of the household. I want to ask you some questions about violence and abuse.* *I will ask you some questions about whether you yourself have experienced violence and abuse, and I will also ask you to tell me whether any children in your household have experienced violence and abuse.* *All of your answers are confidential, and I will not tell your spouse or partner, or anyone else in your household, what you said during this part of the interview.* *Please tell me about any violence or abuse you or children in your household have experienced, whether it happened in your household or outside your household, and whether the person who mistreated you or your children was a family member or someone else. If you or your child have been mistreated, it is not your fault."*	
6.1. In the past 6 months, have you been punched, kicked, choked or beaten by a spouse or partner, or any other adult?	☐ Yes ☐ No
6.2. In the past 6 months, are you aware of any child, adolescent, or youth in your household being punched, kicked, choked or beaten by an adult?	☐ Yes ☐ No
6.3. In the past 6 months, are you aware of any child, adolescent, or youth in your household being touched in a sexual way or forced to have sex against his or her will? Touching in a sexual way could include fondling, pinching, grabbing, or touching a child, adolescent, or youth on or around his or her sexual body parts.	☐ Yes ☐ No
6.4. In the past 6 months, has anyone tried to make you have sex against your will? Please answer "yes" even if this person was a spouse or partner, and even if he tried but did not succeed in making you have sex.	☐ Yes ☐ No
Has Benchmark 6 been met? *If Questions 6.1, 6.2, 6.3, and 6.4 are <u>all</u> answered "No", Benchmark 6 has been met.* *If the primary caregiver refuses to answer a question, this should be taken as evidence of possible violence or abuse, and Benchmark 6 is not met.* *If you see any signs of violence or abuse in the household or suspect such violence or abuse may be happening, even if denied by the members of the household, Benchmark 6 is not met.*	☐ **Yes** ☐ **No**

BENCHMARK 7 (3.1.2): NOT IN A CHILD-HEADED HOUSEHOLD	
QUESTION	**RESPONSE**
Answer the following question using the casefile and your knowledge of the household. A stable adult caregiver is defined as an adult who has cared for and lived in the same household as the child or adolescent for at least the past 12 months. 7.1. During the past 12 months, have all children and adolescents in the household been under the care of a stable adult caregiver?	☐ Yes ☐ No
Has Benchmark 7 been met? *If Question 7.1 is answered "Yes", Benchmark 7 has been met. If you have any evidence that the household has been child headed during the past 12 months, Benchmark 7 is not met.*	☐ **Yes** ☐ **No**

BENCHMARK 8 (4.1.1): CHILDREN IN SCHOOL	
QUESTION	**RESPONSE**
If there are no children or adolescents ages 6–17 years in the household, skip this section. Tick N/A and proceed to the Final Assessment. **The following questions should be asked of the primary caregiver as defined by the project (one caregiver only). Review available records if possible.**	☐ N/A
8.1. Are all children and adolescents in the household ages 6–17* enrolled in school?	☐ Yes ☐ No
8.2. Have all children and adolescents in the household ages 6–17* attended school regularly over the past year (at least 4 days a week on average)?	☐ Yes ☐ No
8.3. Did all children and adolescents in the household ages 6–17* progress to the next level or grade, from last school year to this school year? (In other words, no child or adolescent had to repeat a level or grade this year.)	☐ Yes ☐ No
Has Benchmark 8 been met? *If Questions 8.1, 8.2, and 8.3 are answered "Yes", Benchmark 8 has been met.*	☐ **Yes** ☐ **No**

***Note:** The minimum and maximum ages at which children and adolescents must be enrolled in school to meet Benchmark 8 may be modified according to country guidelines or national policy. For example, if national policy is that children and adolescents are required to attend school only between the ages of 7 and 15, the age range specified in Questions 8.1, 8.2, and 8.3 may be changed to 7–15 years. The maximum age cannot be increased to more than 17 years. Do not ask about youth in the household aged 18-20 who are still in secondary school, even if they are program beneficiaries.*

FINAL ASSESSMENT: IS THE HOUSEHOLD READY TO GRADUATE?

Benchmark 1 (1.1.1): Known HIV status (or test not required)	**RESPONSE**
Has Benchmark 1 been met for all members of the household?	☐ Yes ☐ No
Benchmark 2 (1.2.1): Virally suppressed	
Has Benchmark 2 been met for each beneficiary who was assessed?	☐ Yes ☐ No ☐ N/A
Benchmark 3 (1.3.1): Knowledgeable about HIV prevention	
Has Benchmark 3 been met for each beneficiary who was assessed?	☐ Yes ☐ No ☐ N/A
Benchmark 4 (1.4.1): Not undernourished	
Has Benchmark 4 been met for each beneficiary who was assessed?	☐ Yes ☐ No ☐ N/A
Benchmark 5 (2.1.1): Improved financial stability	
Has Benchmark 5 been met for the household?	☐ Yes ☐ No
Benchmark 6 (3.1.1): No violence	
Has Benchmark 6 been met for the household?	☐ Yes ☐ No
Benchmark 7 (3.1.2): Not in a child-headed household	
Has Benchmark 7 been met for the household?	☐ Yes ☐ No
Benchmark 8 (4.1.1): Children in school	
Has Benchmark 8 been met for all school-age children and adolescents in the household?	☐ Yes ☐ No ☐ N/A
Have all applicable benchmarks been met? *Benchmarks 1–8 ticked "Yes" or "N/A".*	☐ **Yes** ☐ **No**

If all applicable benchmarks have been met, congratulate the household. They are ready to graduate!

IF BENCHMARKS 2, 3, OR 4 REQUIRE ASSESSING MORE THAN ONE MEMBER OF THE HOUSEHOLD, THEN REPEAT FORMS FOR EACH ASSOCIATED MEMBER OF THE HOUSEHOLD.

ANNEX 25: Job Aid: Guiding Questions for Preparing a Household for Case Plan Achievement

Instructions: The purpose of these guiding questions is to facilitate the conversation between the caseworker and members of the family/household on the progress that they have made while participating in the OVC program and plan for their exit. The caseworker should write down key points gleaned from the responses to each of the following questions during the discussion.

CELEBRATING THE SUCCESS OF CASE PLAN ACHIEVEMENT

For caregivers and children:

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 whose help you believe 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 primary caregiver:

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

For the children 6-17 years old:

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

IDENTIFYING REMAINING QUESTIONS OR WORRIES

For caregivers and children:

1 | As we discussed, you are soon going to successfully exit the program, which means thanks to your hard work, you are able to support your family without the activities that were provided by [name providers here]. How do you feel?

2 | Do you have any questions or concerns that you would like to discuss with me that you are thinking about regarding after you exit from the program? For example, is there anything that worries you?

DEVELOPING SOME SIMPLE STEPS TO SUPPORT THE HOUSEHOLD POST-CASE PLAN ACHIEVEMENT

For caregivers and children:

1 | Before you leave the program [name program here], 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 you need it. Would you like my phone number?

2 | Some families who have reached case plan achievement (i.e., graduated) have found it useful to meet with another family that has gone through this same process and has exited the program. Would you like to meet another family who has successfully exited the program?

3 | As you know our organization [name organization] is always in the community. In addition to me, do you know others in the organization who can help if you need assistance?

ANNEX 26: Tool: Case Conference Form

Instructions: The caseworker should write down key points from the case conference meeting, including planned actions and who is responsible. Use additional pages if needed. The form should be added to the family's case file, and agreed actions added to the case plan. A follow-up case conference should be planned to assess progression the planned actions.

Date: _____ / _____ / _____ **Venue**: _____ **No. of participants**: _____

Name of Chair: _____

Agencies, Name, Position and Contact Information of Agency's Representative[s]:

_____

_____

UNIQUE ID	NATURE OF CASE RISKS / NEEDS	CASE SUMMARY	AGREED-UPON / PLANNED ACTIONS	RESPONSIBLE PERSON	TIMELINE

Note: *No client names should appear in case conference proceedings (minutes); planned actions to be updated in individual case plans by caseworkers.*

ANNEX 27: Tool: Monitoring Form for Households Reaching Case Plan Achievement

Primary caregiver or head of household name: _____

Caregiver mobile number: _____

Caseworker name: _____

Caseworker mobile number: _____

Unique identifier code: _____

DOMAIN: HEALTHY	YES/NO OR OTHER COMMENT
▪ All members of the household have been healthy in the past month. ▪ If HIV+, members have demonstrated continued adherence to treatment regime. ▪ No child in the household shows signs of malnutrition.	
DOMAIN: STABLE	
▪ The household continues to be able to plan for the priority needs (school fees and medical costs) of the child[ren].	
DOMAIN: SAFE	
▪ There are no signs or concerns about violence in the household, including for all children, adolescents, and caregivers in the household. ▪ All children remain under the care of a stable adult caregiver.	
DOMAIN: SCHOOLED	
▪ All of the children in the household have attended school regularly since the last visit (i.e., no more than five absences per month) school. ▪ There are no noted concerns about continued schooling, including secondary school or vocational training.	

Household is still ready to successfully exit (case plan achievement): ☐ Yes ☐ No

Case determined ready for closure: ☐ Yes ☐ No

Recommended action plan for the next month: _____

_____

_____

_____ _____ / _____ / _____

Signature of Caseworker ***Date of Visit***

ANNEX 28: Tool: Case Transfer Plan

This form is filled out by the case worker and stored in family file in the event of a transfer. Information should be shared with the receiving organization.

Head of household: _____

Planned date of transfer: _____ / _____ / _____

Reason for transfer: _____

_____

Organization transferring care: _____

Contact information for transferring Case Manager: _____

_____

Organization receiving the family: _____

Household strengths and assets: _____

_____

Ongoing household needs: _____

_____

Services that will be provided by the new organization: _____

_____

_____

Final assistance to be provided by transferring program: _____

_____

_____

_____ _____

Signature or thumbprint of head of household ***Signature of Case Manager transferring care***

Date of next follow-up:	___ / ___ / ____	___ / ___ / ____	___ / ___ / ____	___ / ___ / ____	___ / ___ / ____

Signature of receiving Case Manager: _____

ANNEX 29: Tool: Case Closure Checklist

Instructions: The purpose of this checklist is to outline the steps for storing case files at CSO level once the household has graduated from the OVC program. The case manager should complete the Case Closure Checklist once case plan achievement and subsequent monitoring has taken place, and the household is determined to be ready to successfully exit the program.

1 | Date of case closure: _____ / _____ / _____

2 | Reason for case closure (check): ☐ Case Plan Achievement ☐ Transfer ☐ Attrition

3 | Date household exited from the OVC program: _____ / _____ / _____

4 | Name of head of household: _____

5 | Address of head of household: _____

6 | Phone number of head of household: _____

Case Closure Checklist for Case Plan Achievement	
Case files completed per the protocol	☐ Yes ☐ No
Caseworker has given phone number to household	☐ Yes ☐ No
Head of household linked to a family that has already reached case plan achievement and exited the program	☐ Yes ☐ No
Informed necessary service providers of case plan achievement	☐ Yes ☐ No
Case plan achievement recorded in database of CSO and government	☐ Yes ☐ No
Files stored in a safe place (locked cabinet)	☐ Yes ☐ No
Case Closure Checklist for Transfer	
Care Transfer Form completed per the protocol	☐ Yes ☐ No
Referring Case Manager established time and frequency for follow-up with receiving organization	☐ Yes ☐ No
Informed necessary service providers of care transfer	☐ Yes ☐ No
Copy of family folder sent to receiving organization	☐ Yes ☐ No
Files stored in a safe place (locked cabinet)	☐ Yes ☐ No
Case Closure Checklist for Attrition	
Reason for attrition documented in family folder	☐ Yes ☐ No
Files stored in a safe place (locked cabinet)	☐ Yes ☐ No

Case Manager signature: _____

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