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

FROM THE GROUND UP: DEVELOPING A NATIONAL CASE MANAGEMENT SYSTEM FOR HIGHLY VULNERABLE CHILDREN

An Experience In Zimbabwe

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WORLD EDUCATION



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Acronyms

AIDS	Acquired Immune Deficiency Syndrome	HIV	Human Immunodeficiency Virus
ART	Antiretroviral Therapy	IP	Implementing Partner
BEAM	Basic Education Assistance Module	KII	Key informant interview
CBO	Community-based Organization	LCCW	Lead Community Childcare Worker
CCW	Community Childcare Worker	MIS	Management Information System
CHW	Community Health Worker	MPSLSW	Ministry of Public Service, Labour and Social Welfare
CMO	Case Management Officer	NAP	National Action Plan for Orphans and Vulnerable Children
CP	Child Protection	NCMS	National Case Management System
CPC	Child Protection Committee	NGO	Non-Governmental Organization
CSO	Civil Society Organization	OVC	Orphans and Vulnerable Children
CWO	Child Welfare Officer	PEPFAR	U.S. President's Emergency Plan for AIDS Relief
DCWO	District Child Welfare Officer	UNICEF	United Nations Children's Fund
DCWPS	Department of Child Welfare and Probation Services	USAID	United States Agency for International Development
DSS	Department of Social Services	WEI/B	World Education Inc./Bantwana
FGD	Focus Group Discussion		
HES	Household Economic Strengthening		

Glossary of Terms

Community Childcare Workers are the cadre of workers selected at the community level from village child protection committees (CPCs), which are child protection structures that identify vulnerable children in their communities.¹

Lead Community Childcare Worker is also at the community level, and is selected by the ward child protection committee, and tasked with added responsibilities to manage the group of care workers, report to the district child welfare officer, and provide organization of case conference meetings when the case can be resolved at the local level.²

District Child Welfare Officers are social workers employed at the district level under the Department of Child Welfare and Protection Services. They have statutory authority for case management in child abuse and neglect cases, removing children from homes, deciding alternative placements, and appearing in court for all child-related matters. Cases of abuse and neglect are reported by CCW to the child welfare officers who manage cases and/or refer to specialized services.³

Case Management Officers are non-statutory, registered social workers seconded at the District Departments of Child Welfare and Probation Services, who hold the same responsibilities as child welfare officers, except that they cannot make child removal decisions or appear on behalf of children in court.⁴

Child Protection Committees are multi-sectoral and multi-stakeholder structures put in place at national and sub-national levels to coordinate implementation of child protection interventions at each level. They provide technical advice, mobilize political commitment and advocacy, mobilize resources, and create synergies with other related programs. In addition, they advocate with local authorities, government institutions, private sector, and donors to prioritize commitment of resources and ensure collaboration among stakeholders, report yearly progress for children, meet to discuss priorities, oversee grants, and ensure child participation.⁵

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

2 Interpretation of what is presented in the National Case Management System documents.

3 Ibid.

4 Ibid.

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

Objectives of the case study

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

The information used to inform this case study was collected during a desk review of relevant project documentation, as well as through key informant interviews (KII) and focus group discussions (FGD) conducted during a field visit to Zimbabwe in February 2016. The field visit included both urban and rural sites and discussions with stakeholders from the village up to the national level. In total, 24 documents were included in the desk review and discussions were held with 84 people. Stakeholders included caregivers, ward-level community childcare workers (CCWs), lead CCWs (LCCWs), district-level child welfare officers (DCWOs) and case management officers

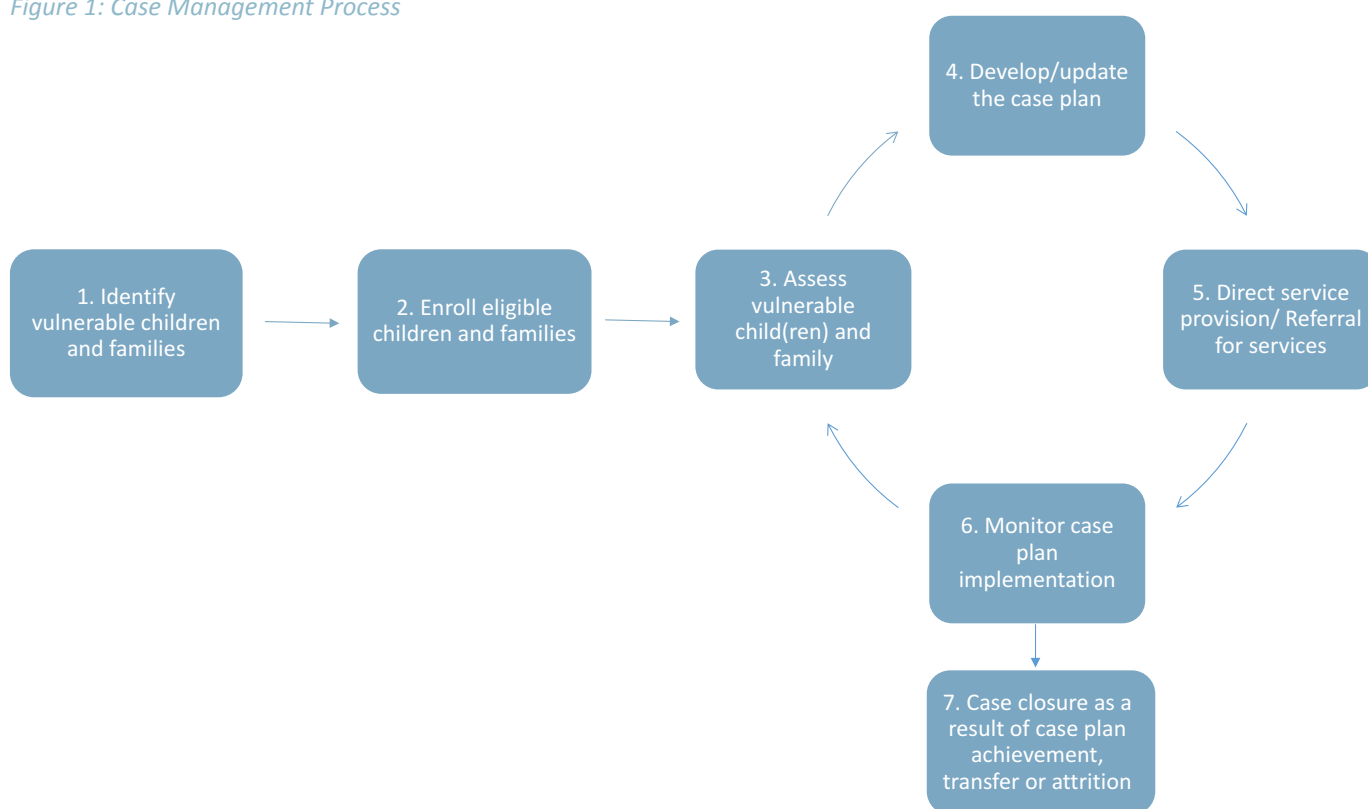
(CMOs), members of ward and district child protection committees (CPCs), provincial-level child welfare workers (CWOs), district administrators and representatives of other district offices (health, education, social welfare, etc.), schoolteachers, community leaders, representatives of the faith community and of community-based organizations (CBOs), and representatives from the Ministry of Public Service, Labour and Social Welfare (MPSLSW) – Department of Child Welfare and Protection Services (DCWPS), World Education Inc./Bantwana (WEI/B) leadership and program staff, UNICEF, and national non-governmental partners. This process was not an assessment, but rather an opportunity to observe case management in action, speak with those responsible for specific components of the case management system, and hear the voices of those who are served by the case management system.

Country overview

POVERTY AND CHILD VULNERABILITY IN ZIMBABWE

The current population of Zimbabwe is estimated at approximately 15.25 million, with over 60% living in rural areas.⁶ Zimbabwe is categorized as a low-income country. Improvements in economic development since 2008 are evidenced by the steady increase in gross domestic product, reaching \$14.2 billion in 2014. However, natural disasters – including the present drought and resulting food crisis, economic and political instability, high unemployment, and the high HIV prevalence rate – contribute to poverty, vulnerability, and food insecurity.⁷ Falling into the *Low*

Figure 1: Case Management Process



6 2014 data retrieved from World Bank: <http://data.worldbank.org/country/zimbabwe>

7 UN World Food Programme: <https://www.wfp.org/countries/zimbabwe/overview>

Human Development tier, Zimbabwe ranks 155 out of 188 on the 2015 Human Development Index, down from its 2013 ranking of 158.⁸ In 2014, 72.3% of the population was living below the national poverty line, and 44.1% was experiencing multi-dimensional poverty, which considers income poverty, education, health, and standards of living.⁹ Literacy rates are high: 92% of women and 86% of men are literate.¹⁰

Zimbabwe is hard hit by the HIV epidemic. One in every ten people is living with HIV, even though there has been a dramatic decline (42%) in new infections between 2001-2013.¹¹ *The country is one of nine countries in the same region that has witnessed a similar percentage decrease in the number of people dying annually from HIV- and AIDS-related causes. These health gains are attributed to behavioral prevention interventions and use of antiretroviral treatment (ART) over the past years.*¹² An estimated 12% of children ages 0-14 are living with HIV. Data from 2012 highlighted that AIDS had orphaned 947,000 children.¹³

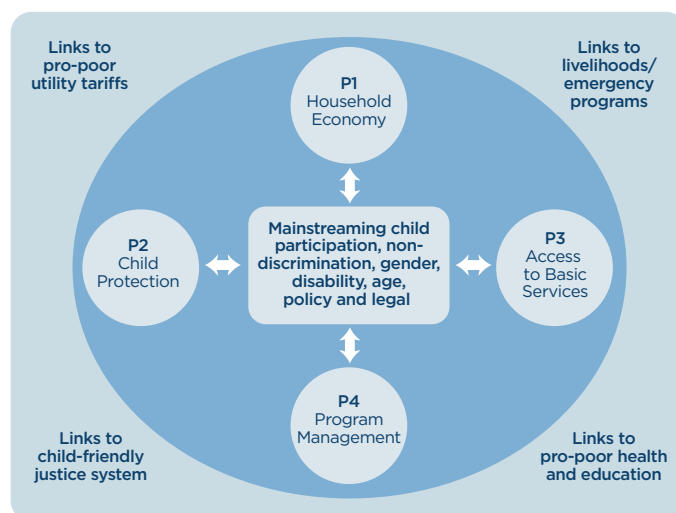
Children make up 50.3% of the population, and face many challenges to their well-being including:¹⁴

- 18% of children have one or both parents deceased;
- 26.6% live with neither biological parent;
- 30% of young women are married before the age of 18;
- 22.4% of young women had at least one live birth before the age of 18;
- Over 33% of children suffer from chronic malnutrition;¹⁵
- 32.3% of births are not registered, increasing to 35.4% in the poorest 20% of households;
- 21.6% of children ages 36-59 months attend early childhood education;
- 73% of school-age children enter first grade.

THE SOCIAL SERVICE SYSTEM IN ZIMBABWE

In Zimbabwe, the Ministry of Public Services, Labour and Social Welfare (MPSLSW) and its two sub-departments, Department of Social Services (DSS) and Department of Child Welfare and Probation Services (DCWPS), are mandated with policy, programs, and services related to vulnerable populations, including children and their families. The MPSLSW plays an important role in overseeing all non-governmental partners who work in services for children and vulnerable populations. In order to improve services to children, the DCWPS was established in 2014, and is staffed by four national-level child welfare officers (CWOs). They are responsible for quality control of case reports (e.g., court reports for adoption), receiving and reviewing monthly

Figure 2: The NAP-II Social Protection Framework



activity reports from the provinces and districts, liaising with government partners, providing policy inputs, and flagging policy issues to the MPSLSW directors. WEI/B technical support has included strengthening capacity at this national level. A Provincial Child Welfare Office in each of the 10 provinces (including two metropolitan centers) represents the DCWPS. Each of these ten departments oversees a number of the country's 65 districts and their district-level DCWPS office. At the district level, there are district child welfare officers (DCWO) with statutory responsibility for management of cases of abuse, neglect, and extreme vulnerability.

Some 1,200 wards exist within the districts. Wards represent the lowest administrative level in Zimbabwe, and are made up of individual villages. Vulnerable children and families are identified, assessed, monitored, and referred for essential services at the village level by volunteer community childcare workers (CCW) who are supervised by a lead community childcare worker (LCCW). The LCCW is based at the ward level in the community. The ministry's work is guided by a well-developed policy framework that includes commitments to international and regional conventions such as the United Nations Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child. The Children's Act of 2001 is the primary national policy supporting children's rights, while the second National Action Plan for Orphans and Vulnerable Children 2011-2015 (NAP-II) was, until December 2015, the key guiding policy.¹⁶ The NAP-II (see Figure 2), recognizes the family as critical to healthy child growth and development; one of the objectives was *"Strengthening case management and referral systems for community-based care services and support systems for vulnerable children, which include community-*

8 Human Development Report (2015). http://hdr.undp.org/sites/default/files/hdr_2015_statistical_annex.pdf

9 Ibid

10 Ibid

11 Zimbabwe National Statistics Agency (2015) Multiple Indicator Cluster Survey. <http://microdata.worldbank.org/index.php/catalog/2527>.

12 Ibid, page 282

13 PICES 2011/2012 as cited in Ministry of Public Service, Labour and Social Welfare (2015) National Case Management System for the Welfare and Protection of Children in Zimbabwe.

14 Zimbabwe National Statistics Agency (2015) Multiple Indicator Cluster Survey.

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

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

based initiatives and social safety nets addressing, among others, disability, gender-based violence, child abuse, street/abandoned children.”¹⁷

The NAP-III is presently under development, and is expected to improve and expand the National Case Management System (NCMS), which is modeled after the case management models piloted by many NGO partners, including WEI/B. The policy framework that supports case management, as of December 2015, includes the National Case Management Framework¹⁸ and the accompanying Operations Manual.¹⁹

From community-based case management to a national framework

The Bantwana community-based case management model was designed by the Children First program (2008-12), supported by the United States President’s Emergency Plan for AIDS Relief (PEPFAR) and United States Agency for International Development (USAID).²⁰ Children First set out to develop and test promising models of community-based care for OVC to mitigate the impact of HIV and AIDS on children. The case management model was built on the culture of community care that exists in Zimbabwean communities to ensure that vulnerable children receive the care and support they need. The Children First case management system was piloted in one district beginning in 2011. The pilot aimed to provide comprehensive services for OVC, and focused on building the capacity of a cadre of community-based volunteers, the CCWs.²¹ The program also supported the community child protection committees that operate under local leadership and link to the district office of the DCWPS through a district child welfare officer (DCWO). In partnership with DCWPS, the model was rolled out to ten districts in 2012. These were the same districts in which the Government and UNICEF were piloting the National Cash Transfer Program, and intentional linkages between both efforts were established. For example, purposeful linkages were made between case management and internal savings and loan initiatives, and case managers were able to link household work with the harmonized social cash transfer for economic support. Lessons learned from Children First influenced the cash plus care model implemented in the roll-out. Children First served 90,000 children annually with comprehensive services considered to be cost effective and innovative.²²

The project grew into an important national partnership between WEI/B, MPSLSW, UNICEF, and other implementing partners. The National Case Management System (NCMS) transitioned from a model to a national system when the Government of Zimbabwe adopted it as the preferred way

of supporting vulnerable children.²³ In 2015 the NCMS was scaled nationally. The National Case Management System Framework and National Case Management Operations Manual were officially launched in December 2015, thereby showing official endorsement as the standardized approach to care and protection. One of the national program’s first objectives was to identify and recruit CWs in every community from people already in the community. At the time this case study was developed, there were close to 9,000 CWs in place, trained and supported by a district CWO in every district.²⁴ The WEI/B program has scaled up the national model to 21 districts, while different NGOs, UNICEF, and/or Government support the other districts. One of the strengths of the NCMS is that actors at various levels, both government and non-government, have a similar understanding of case management. The NCMS describes case management as a way of coordinating children’s services so that children’s cases are handled in an appropriate, systematic, and timely matter.²⁵ The terms that people use to define case management for OVC in Zimbabwe include “standardized,” “harmonized,” “better integrated,” and “more coordinated.”²⁶ One caregiver that took part in a FGD commented, “We understand case management to mean to walk the child all the way through.”²⁷ This is a powerful analogy for the objectives of the NCMS. These objectives include:²⁸

- To establish a standardized “wrap-around” response service system that protects children from abuse, violence, exploitation, and neglect within a coordinated continuum of care;
- To strengthen child protection systems through linkages between community child-protection mechanisms and the formal child-protection system;
- To reduce children’s exposure to harm through actions that strengthen the protective environment for children in all settings;
- To establish a system for knowledge management, monitoring, and promotion of quality child protection services informed by ethics and standards of practice.

KEY ACTORS WITHIN THE COORDINATED CARE APPROACH

The NCMS model centers on community volunteers or CCWs, of which there are now almost 9,500 in all 65 districts.²⁹ Some are volunteers who have experience with NGO OVC programs and are newly recruited from within the community. The new recruits were selected by their CPCs with oversight from the DCWOs. WEI/B helped DCWOs to facilitate community meetings that included CPCs where the new CCWs were

17 Ibid, page 20.

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

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

20 For more information, see <http://bantwana.org/where-we-work/zimbabwe/children-first/>

21 Under the Children First project this cadre was referred to as case care workers; now under the expanded national program the government has endorsed the term child care worker.

22 World Education Inc./Bantwana (2015). Innovations in Systems Strengthening at Community Level: The Case Management Model.

23 For more information, see <http://bantwana.org/where-we-work/zimbabwe/national-case-management/>

24 According to several interviews with key stakeholders, February 8, 2016.

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

26 According to key informant interviews, February 2016.

27 According to caregiver participant from key informant focus group, February 2016.

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

29 Figures per group interview with representatives of DCWPS.

chosen based on the set criteria. The criteria for selection are outlined in the NCMS Operations Manual, and include recommendation of the community and/or ward CPC, verbal and written communication skills, police and community clearance, and commitment to confidentiality.³⁰ Vetting of the new recruits involved both community and police (i.e., criminal background checks) vetting. Rural wards have five CCWs because these areas tend to have more limited access to services, higher concentrations of vulnerable households, and wider geographical spread, whereas urban wards will have three CCWs. One lesson learned from the WEI/B program was that it is easier to transition community volunteers who have never been motivated financially, than to transition those who received stipends for their work. Unpaid volunteers are motivated by the “tools of the trade” they receive, including bicycles, logo uniforms and t-shirts, cellular phones and air time, consumable office materials, solar lanterns, and solar power stations, which also give them status as Government representatives in the community.

CCWs also feel motivated by the training that they receive, which gives them a sense of qualification and prepares them for their work with children. One CCW shared, *“We were trained, and then we were given our regalia. We feel important to the community.”* The pre-service training is five days long, and is conducted using a CCW training manual developed by WEI which includes an overview of the situation of OVC, an introduction to case management, the legal framework for child protection, guidance for communicating with children and working with children who have special needs, and the CCW code of conduct.

CCWs have a central role of identifying vulnerable children and families, coordinating care and making referrals, and following up on primary cases, such as school enrollment and birth registration. Their role is initial identification and direct casework on basic child welfare cases. They carry an average caseload of five to seven open family cases at any given time. A LCCW oversees a group of their peer CCWs, and provides the link to the district level

Preparation of Community Child Care Workers

Through the WEI/B project, CCWs gain:

1. Skills to identify, reach, and respond effectively to vulnerable children who need assistance.
2. A comprehensive understanding of available community services and methods to make and follow up on referrals to community and government service providers.
3. An understanding of case reporting structures and protocols (and related tools) between the community, district, and national structures.



The national case management system model depends on community case volunteers who meet regularly with children and families who need extra support.

Photo by WEI/Bantwana

statutory child protection services. Cases of child protection risk or concern are referred up to the district level from the CCWs and LCCW. The LCCW may also be responsible for five to seven family cases. LCCWs work with their team of CCWs to determine who will work with which cases, and if any cases need to be referred higher due to protection risk. In providing supervision for the CCWs, the LCCW meets with a group of peers (average group of four to five) every month or more often if warranted. Group discussions focus on reviewing case, sharing ideas and strategies for addressing challenges faced by clients, problem solving, addressing the emotional strain of working with OVC, and related coping strategies. Most LCCWs have received extra training in peer supervision, however this is one area of the program that needs further strengthening. Not all have been trained, and there is a need for ongoing training. This need is in part due to the fact that supervisor-to-supervisee ratios are quite high (in some areas CWOs may have 300 CCWs under their jurisdiction), and therefore peer supervision can provide an additional quality check as well as more immediate support mechanism. Additional training for LCCWs would further enhance skills in how to provide and encourage peer-to-peer support.

Professional (university-trained) social workers are required for the positions of CWO or CMO at national, provincial, or district levels. Historically, Zimbabwe has had a strong social work community supported by a Regulatory Act³¹ and an established Council of Social Workers for the profession in place since 2001. The role of a social service workforce in supporting vulnerable people is not new. As UNICEF staff explained, *“This is not totally new stuff. Social services are well understood since the 1980s. So there was somewhat of a system in place already.”* Even though migration for employment and lack of professional recognition led to a serious shortage of trained social workers,³² there are now close to 900 professional social workers registered.³³ CWOs are the first-line statutory workers with responsibility for receiving referrals of abused, neglected, or separated children, managing these cases, and coordinating care services at the community level. CMOs are an additional

30 Ministry of Public Service, Labour and Social Welfare (2015b)

31 Parliament of Zimbabwe (2001). Social Workers Act 27:21, number 9/2001.

32 Ministry of Labour and Social Services and UNICEF (2010). Capacity Assessment: Department of Social Services, Ministry of Labour and Social Services, Final Report.

33 According to an interview with the Zimbabwe National Council of Social Workers.

Family Clubs

CCWs also run Family Clubs in their communities where parents come for knowledge and skills-building sessions on various topics, including HIV. Working with community members in family clubs, CCWs can both identify vulnerable families affected by HIV and other challenges for follow-up, and provide awareness and education on related topics, such as providing a protective and safe environment for the child. The Family Clubs also play a critical preventative role by ensuring families have social connections and capital which they can access for support. These clubs have been a good way to raise awareness about the role of CCWs and case management.

district-level cadre with the same case management responsibility as the CWO, but they do not have the statutory authority to remove children from the home or to represent a child's interests in court. Presently they tend to be seconded by NGOs or donors, and are considered by Government to play a complementary role to support the CWO.

Having the roles and responsibilities for abuse and neglect cases clarified and better coordinated through policy and national guidance is believed to have eased the work of the social service workforce at both local and district levels. One CCW stated, *"Before, the paperwork at the community level was so cumbersome. We are happy to have the district do it. Our work is simpler and more direct with the family now."* And a CWO tells us, *"The CCWs make our work easier because they are better now at identifying cases and the right cases are getting to us. They also help us with follow-up."*

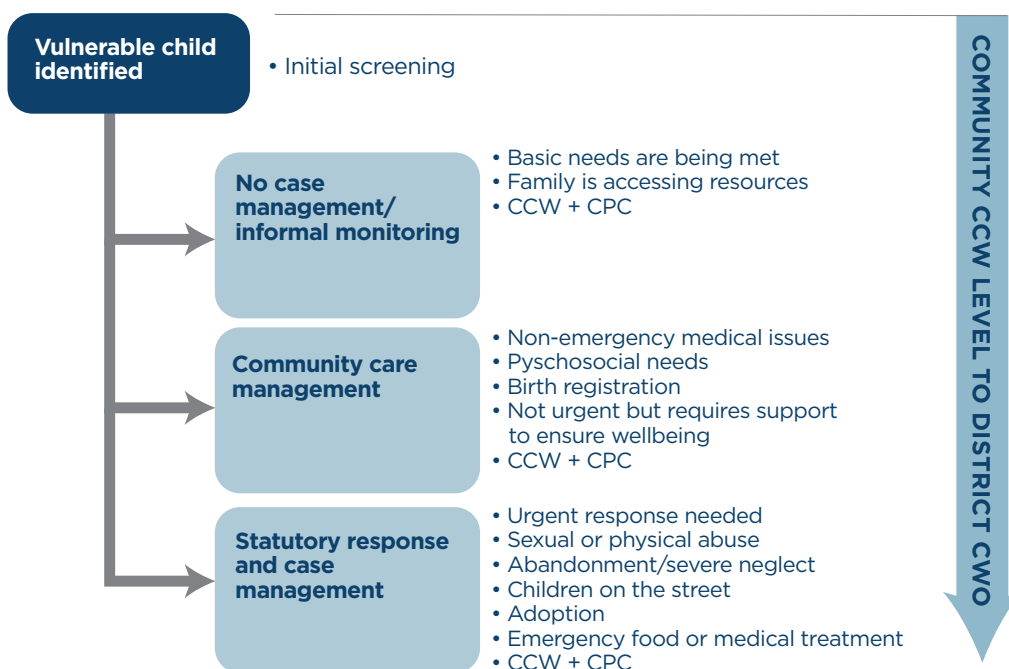
The Ministry's DCWPS has overall responsibility for child protection and coordination within the sector. Policy development and decision-making is primarily done at the national and provincial levels. Actors at these levels might include government ministries, the national DCWPS, district DCWPS, district and provincial CPCs and the Victim Friendly System Sub-Committee, and civil society service partners.

The coordination between local communities, districts, and provinces was believed to be particularly effective within the case management model, especially in provinces where there had been longer term investment in the NCMS roll-out, and child protection actors at all levels have more experience. *The effective functioning of the NCMS relies on the consistent communication of information on all levels.*³⁴ Theoretically, in the NCMS the information on service delivery is generated in the community and flows upward, but feedback and follow-up also flow back down. CCWs noted appreciation for the fact that they receive information about the cases that they refer to the district, and even for cases referred up to the national level.

IDENTIFICATION

In the NCMS Operations Procedures, identification is the very beginning of the *intake process*, whereby information is received about alleged child protection violations or concerns about unmet needs (Figure 3). The identification of vulnerable children happens at the community level where reports are received by either CCW or the ward CPC. Cases may be brought to their attention by schools, health workers, community leaders, churches and other community groups, and organizations. Attendance by all of these actors in the CPC means that identification is understood to be a role of the whole community. Vulnerability and identification of risk is also addressed in CCW

Figure 3: Assessment and Intake in NCMS Operations Procedures



34 Ministry of Public Service, Labour and Social Welfare (2015). National Case Management System for the Welfare and Protection of Children in Zimbabwe, page 23.

and CPC training. The case intake form and initial assessment are tools used in identification and enrollment.

Not all vulnerable children will be in need of case management. At identification and intake, an initial screening using the NCMS assessment tool might find the child is living in a supportive environment and his/her basic needs are met in the most realistic manner possible, and that the family is accessing available resources. Some vulnerable children or “children in need” may require case management to improve their well-being, but the concerns they face may not be urgent. These non-urgent concerns may include non-emergency medical issues, psychosocial needs, or birth registration, for example. Caregivers commented, *“The most important thing is that now we are all acting in a preventative way. Even as grandparents and caregivers, we know now what it means to protect children and we are almost like CCWs – we can say to our neighbors ‘you can’t treat the child that way’ we can call them to responsibility.”* Some children and families are beginning to self-refer as the roles of the CCWs and CPC are becoming more known and trusted in the community. Cases of abused and neglected children also continue to come through the national hot line operated by Child Line. In some situations, CCWs prefer to remain anonymous and they will call Child Line, for example, if a situation is too close to their community or familial connections. One LCCW said, *“We have child protection cases and we have child welfare situations; child protection goes up a level and child welfare, like birth registrations, we can handle locally.”*

INTAKE AND ASSESSMENT

Once a child has been identified as a potential victim of child rights violations, according to the NCMS Operations Procedure, the CCW must complete an intake form, and must conduct an initial assessment within 48 hours. All assessments collect information on the child’s physical status, psychological status, social functioning, cognitive/educational needs, losses or previous trauma, and other problems that will need to be addressed. The following actions help to determine who is eligible for what services. From the initial assessment process actions might include:

1. A decision that no action is required; when a decision is made that no action is required, the CCW or community members may follow up informally. For example, the CCW may hear that a child has not been attending school, but a talk with the child and caregiver is enough to get the child back to school and the CCW determines there are no additional risks or rights violations.
2. A complete assessment within seven days that leads to a recommendation and case conference. For example, a complete assessment indicates that a child requires medical support and that the household would benefit from a cash transfer. A case plan is developed, referrals are made, and the CCW works with the family to access services and address needs.
3. An emergency action, such as immediate removal of a child from a harmful situation to a temporary place of safety where a full assessment can be done and a care plan made.



After identification, the first steps of the case management process are intake, assessment, and the development of a case plan. Shelton, a community case worker, meets with a caregiver and his 13-year-old grandson for joint development of a case plan.

Photo by Nicole Brown

The initial intake assessment will include:

- Information on the nature of the concern;
- How and why the concern has been raised;
- Whether or not the concern involves abuse or neglect;
- What the child’s immediate, medium, and long-term needs appear to be;
- Whether or not there is need for urgent action.

CCWs are trained in making initial informal assessments, and are clear about when to refer more complicated cases or cases involving more serious concerns up the chain to the CWO. At the village level, the village register, which includes information about community member vulnerabilities (such as food insecurity, orphanhood, child-headed household, etc.), is used by the CPC to keep track of families and children who might benefit from informal assistance, or who may need to be monitored because they are at risk for child protection issues. At the same time, the village registers have limitations. For example, they do not necessarily support the dynamic process of case management – they provide a one time snap shot. They are also held within the traditional village leadership, which can sometimes lead to concerns about confidentiality or prioritization for services because the leaders do not receive the same training as CCWs. CWOs and CMOs receive more comprehensive and formal child and family assessment training beyond just how to collect information for the village register.

The role of children and family members in the assessment phase of the case management process was not clear from the case study field visit, and may be an area for further improvement.

DEVELOPMENT OF A CASE PLAN

Following the assessment phase, once a case has been opened, the NCMS Operational Procedures outline the

process of care planning. The main objectives of a care plan, based on the child's best interests, should be:

1. To ensure that the child is safe and living in a non-abusive environment;
2. To enable the child to live at home with his or her birth family, or, if that is not possible, to live with relatives;
3. To ensure the child has access to educational opportunities, health care, and resources to support healing from trauma.

The care plan includes an action plan in which specific one-time or regular actions are listed including: the specific needs of the child and/or household, household resources (including informal resources), steps required to address the needs of the child and/or household, resources that will be accessed, the role of family in addressing the needs of the child and/or household, and psychosocial supports the CCW will offer. The actions could include a schedule of home visits or a plan to take the child and family to a clinic to access health care. The care plan also clearly identifies who will be responsible for actions. In addition, the care plan provides the criteria upon which to review the case, monitor progress, and make adjustments as the situation for the child changes.

While the procedures do suggest that the family member or caregiver with whom the child is living should be involved in the care planning, it was not clear from the case study field visit how they were engaged. Nor was it clear if, when, or how children participate in care planning.

IMPLEMENTATION OF THE CASE PLAN

Stakeholders recognize the national case management model as particularly successful in coordinating service delivery and referrals. Because, for the most part, CCWs live in the community with families, following up on the provision of services and referrals outlined in the care plan occurs as part of the case management process. Services are provided to children and households either directly by CCWs, CWOs/CMOs, or through referral to other services. Direct services provided by CCWs or CWOs/CMOs might include informal, home-based, one-to-one support and guidance provided to

Example of Care Planning

The community CCW finds an abandoned baby and calls the police. The police notify the CWO. The CWO makes an emergency decision to place the child with an emergency foster care family for seven days (and later follows up with the court for a formal decision). The CWO completes a care plan for the baby with input from the CPC. The police complete a search for the mother and the court makes a decision to place the child in longer term foster care, make the child available for adoption, and/or place the child in a residential care facility. The care plan and services include a plan for permanency, regular visits by CCW or CWO, and a holistic package of services such as well-baby visits, vaccines, day care, or other early childhood development services.



Referrals for essential services such as early childhood education programs require a strong system of community service mapping and linkages.

Photo by WEI/ Bantwana

the child or caregiver during home visits, organizing family clubs or other support groups, accompanying the child or family to clinics, etc. In more complicated cases, case conferencing may be used to ensure that children can access the services they need. Case conferencing might involve multiple agencies in order to ensure collaboration and coordination. Case conferencing helps to unlock bottlenecks in situations where, for example, a case is not progressing through goals or where a child is at high risk.

Support provided directly by CCWs or CSOs/CMOs was not observed to be particularly goal-oriented or systematic, and this was identified as an area that might benefit from further strengthening. Services were informal and primarily involved monitoring the child and household through regular home visits for a fixed period of time. For example, often caregivers are expected to attend Family Club meetings indefinitely. Meetings focus little on increasing the self-sufficiency of households through economic strengthening activities or structured efforts to improve parenting skills. It was unclear how services recommended within care plans were intended to help children and caregivers reach a point at which they would no longer require case management or direct support from CCWs or CSOs/CMOs.

Community service mapping supports referrals. The NCMS recognizes that it takes many stakeholders to provide all of the services that a child or household may require. A number of stakeholders also mentioned that the dearth of services was a challenge. *"It is disheartening when we make a referral and try to mobilize resources, but there's nothing and you don't want to let the child go without solving the case,"* declared one provincial officer.

The NCMS outlines the process for referrals stating, *"In order to address the needs identified on the care plan, links with additional providers need to be made. Successful linkages are key to the success of the NCMS."* Referrals are typically made to:

- Cash transfer programs, such as that being piloted by the Government of Zimbabwe and UNICEF;

- Basic Education Assistance Module (BEAM) (educational support grants);
- NGOs, CBOs, faith-based organizations (FBO), and others providing school fees, school uniforms, and food;
- Hospitals and health clinics for health services, including HIV testing and services;
- Police for domestic disputes, violence, etc.

Good practices for service delivery and referrals identified by those interviewed include:

- Being familiar with the service you refer to – never referring unless you know there is someone on the other end to receive the family or child;
- Accompanying the child and/or family to the service;
- Consistency in who follows up with the child, family, and/or service provider (most often the case worker);
- Following up at the community level, where the child and family live.

Government actors at all levels and some NGO partners reportedly use a common referral form. The process of referring cases for government child protection services is able to branch different administrative levels, and cases are effectively referred from the community level to the district level and more complex cases are referred from the district level to provincial or national levels. *“Before NCMS a child might get one service – whichever one identified the child – but now it is comprehensive depending on each case,”* stated a district administrator.

PROGRESS MONITORING

The NCMS Operations Procedures state that *care plans must be formally reviewed at least every six months*, and case review is part of this process. Some cases may be reviewed more often if new needs arise, change seems to be stagnated, or conversely if a problem has been resolved sooner than expected. This is decided on an individual basis by the case care worker regarding his/her household case load, and based on the criteria in the NCMS assessment tool. For example, if there is a significant change in the family (e.g., a caregiver moves or there is a death) a care plan review will be done immediately. Case review involves returning to the assessment and case plan, and identifying what has changed and what has not changed, particularly regarding the child and/or households needs and resources as well as the outcomes they desire. The action plan is also reviewed to determine what progress has been made (e.g., what services have been accessed and what actions have been completed), whether the actions are still required or new actions might be more appropriate, and whether timelines are still reasonable. The procedures suggest that both caregiver and child should be involved in this process and work with the case worker to determine if their case should be closed, or whether new objectives and actions should be established.



Case closure can only occur after a team case conference determines that all the indicators in the action plan have been met and the child and family can move forward without services or support.

Photo by WEI/Bantwana

Regular home visits that are scheduled based on the individual needs of each case are important to monitoring cases as well. Contact with the child and family provides opportunities to ensure that services and resources are being accessed, referrals are being followed through, and that guidance and support are offered in a timely manner. Home visits also monitor for child protection issues and provide face-to-face interactions with the child to ensure the child’s perspective and opinions on how the household is improving are taken into consideration and documented.

CASE CLOSURE

Case closure occurs when the child or family have met all of the objectives outlined in the individual case plan and can care for children adequately without the regular and direct support of the CCW³⁵. The case closure form, used with the case plan and case review, helps to determine child well-being and readiness to exit the program. Essentially planning for and working towards fulfillment of the case plan begins when the objectives and activities are outlined with the family in the case plan. Case reviews provide an opportunity to check progress toward meeting objectives and engage in further planning to reach a state where case closure is considered appropriate. Before closing the case, the child and caregiver should demonstrate that the actions or objectives outlined in the case plan have been completed and the child is safe and their well-being is relatively stable. In order to close a case, the caseworker must be convinced that all safety and care concerns have been addressed. The NCMS guidance suggests that cases be reviewed through case conferencing by a multi-agency team (e.g., CPC, CCW, health agency/clinic, school, implementers of household economic strengthening, etc.) every six months or sooner if deemed necessary. Case closure is a disciplined process involving review by the district CWO or supervising social worker, or in more complex cases, review by the provincial-level officer. Ideally, case closure should be planned for from the beginning of assessment (*what will be needed to ensure full protection and well-being?*), care planning (*what are the goals that the child and family should be working toward with the case worker?*), and through to closing the case (*have the goals been met, and are all supports in place?*).

35 The term case closure is used within the program to define a state wherein the objectives and activities outlined in the family case plan have been met. This concept is similar to the term case plan achievement, which is currently being promoted within OVC programming.

While the NCMS includes a clear protocol for case closure, the case study field visit revealed ongoing confusion around specific criteria against which to measure “readiness.” In addition, the protocol can be challenging to implement due to logistics challenges in coordinating case conferencing, lack of clear graduation criteria to determine when children and families are safe and stable, and the lack of other service providers to support children after cases are closed.

A case is closed when one or more of the following criteria are met:

1. The actions outlined in the care plan have been completed, and the child is deemed to be in a situation of safety.
2. Child has reached age 18.
3. The child dies (closure).
4. The case is transferred to another agency, provider, or to the DCWPS in a different district (transfer).

While these criteria seem clear enough, CCW and CWO indicated that it is very difficult to close cases once they are opened. Some of the concrete challenges to closing cases that were mentioned include:

1. Many cases involve statutory decision-making by the court, and proceed very slowly as the courts are not versed in child protection. Therefore, a case will remain open for a long time because the child can not achieve the goals in his or her care plan without a legal decision.
2. Social workers are sometimes unable to find a home for children that is safe, and from which they can access appropriate services. As a result, these children must legally remain in the care of a social worker until they turn 18.
3. Cases involving child abuse (e.g., statutory cases opened by district offices) must be authorized for closure at the provincial level, and there is a backlog of cases at this level.

At the local level, the role of supervision is critical in the closure process and, says one government official, “*We are still struggling with defining case closure, knowing when the most critical is taken care of, knowing what does that look like.*” This difficulty is linked to the lack of services mentioned earlier, and workers not wanting to close cases without knowing that the family and child will have the supports and resources they need. Many of the child protection cases rely on judicial proceedings or other process outside of the DCWPS responsibility. For this reason, some protection cases (e.g., sexual abuse cases) are open longer. There appears to be limited understanding of how to plan for and work toward achieving self-sufficiency, even while it is noted that case closure has been improving and that the WEI/B work has been contributing to improvements.

In the process of closing cases, the CCWs are assisted by LCCW and CPC and supervised by the CWO/CMO. As noted, the NCMS guidance requires case review every 6 months, if not sooner, based on the needs of the case. Regular communication and supervision are also facilitated

through the use of technology such as cell calls, emails, and group *WhatsApp* chats. Using these platforms, workers can conference on cases and talk with each other to come to a consensus regarding decisions to close a case.

DATA COLLECTION, STORAGE, AND USE

Management information systems (MIS) – data collection, analysis, and use to inform and improve implementation – is one of the areas recognized by WEI/B and partners, including the Government, as needing additional attention and investment. Data management is described as *critical to moving national case management systems further*. The Government describes getting the MIS issue right as important to national decision-making, and therefore has placed it as a top priority. A national MIS is under development and has been piloted in five districts. It aims to increase the consistency of data and provide data access/sharing to more actors and across sectors. One of the challenges to the data-sharing protocol is the right to privacy, especially for children, and figuring out who needs access to information. The hope is the new system will improve national-to-district (and vice versa) input and access.

Although there is currently not MIS at the sub-national level to help with data collection and reporting, the provinces provide a weekly report to the national DCWPS. Collection is all paper-based, cumbersome, and sometime duplicative between levels. One of the difficulties is the presence of only one CWO at the district who has responsibility for case management and data collection and reporting, as well as for training and supervision of workers at the community level. On average CWOs have 144 CCWs under their jurisdictions, but in some districts, such as the district of Chivi, there could be as many as 300 CCWs under the supervision of one CWO.

According to the national DCWPS, the province and district report standardized statistics, such as the number of abuse cases, neglect cases, and juvenile delinquency cases, as well as awareness campaigns completed and new CCWs hired. Beyond this they are expected to provide an analysis of those statistics, or in other words, *what does any change in number of cases mean?* Useful information from the community level might include child basic biographical data, family contact details, number of cases by type, and information from case logs. District level information can include case trends, caseload analysis, supervision requirements, numbers of opened and closed cases, child basic biographical data, information from needs assessment, referrals and follow-ups, service provisions, etc.

The new MIS system hopes to provide case modules that include intake, assessment, review, referral, and closure. The design includes a desktop application for internal government use, a web application that will also give access to partners, and eventually a mobile application with a case management interface. WEI/B expressed concerns that what is being designed “*may be too sophisticated, and that people are not yet using it as such,*” adding, “*We must figure out the difference between the ‘nice to know’ and the ‘must have’ in terms of information.*” These considerations have informed the review of the MIS, including the need to have simplified

tools that will reduce the amount of time spent on capturing data. Access to the Internet in some areas and computer literacy among end users are challenges.

Conclusion: Building a system from the ground up

There was general agreement that the NCMS in Zimbabwe was here to stay. Those interviewed agreed that the effort spent by the Government, NGO partners, and donors on raising awareness about child protection and the response system was well worth the investment, and contributed to building an overall system of care for children. *“The synergy created through the process has been very useful in leveraging resources,”* commented UNICEF representatives. *“Case management has been like a ‘glue’ that helps to bind the other OVC interventions and programming,”* said the program manager at WEI/B. Case management has helped increase enrollment and attendance in schools, HIV testing, children’s adherence to ART, and at the same time is helping with increasing a more coordinated response to child protection across sectors such as school, police, health, and protection.

There were inception meetings for sensitization and community mobilization on the NCMS. From there, those who were already natural helpers in the community and involved with the CPC were engaged as CCWs. *“Initially people thought CMS was coming to provide services in communities. They thought it was about material things. They thought it was about bringing people things, and now they appreciate that children need protection and not just food,”* said a representative of the DCWPS. Identifying community focal people is helping to continue efforts to raise awareness, something they have learned is an ongoing process. At the community level the right people are in place, and there is standard and consistent use of the established case management tools.

WEI/B was intentional in involving Government partners from the beginning. They knew that in order to bring the model to the next level, they needed to show the government case management in action. Taking representatives into the field to see how it worked made a big difference. Additional methods to institutionalize case management include national working groups and steering committees, partnerships between larger NGOs with community programs, and donor forums for coordination of roll-out and resource leveraging. At this point national case management in Zimbabwe is reflective of the work of many, not just WEI/B, a fact they humbly recognize.

Case management still faces many challenges. Many recognize that Zimbabwe continues to be very dependent on donors, and that the NCMS is vulnerable to donors’ interests and investments. As the system rolls out nationally, there

are still many needs: new workforce training and regular in-service training of CCWs, stronger supervision mechanisms and standards of practice, and the provision of resources for the work. At the district level, one CWO cannot handle the number of statutory cases requiring his/her attention, particularly as those cases identified become more and more complex. Just the same, perhaps one of the most remarkable features of the program is the recognition and common understanding of the imperfections and work that remain ahead.

Annexes

Annex 1: Documents reviewed

Africaid (no date). Case Management forms including assessment, case plan, case file classification, case file review, intake sheet, referral note.

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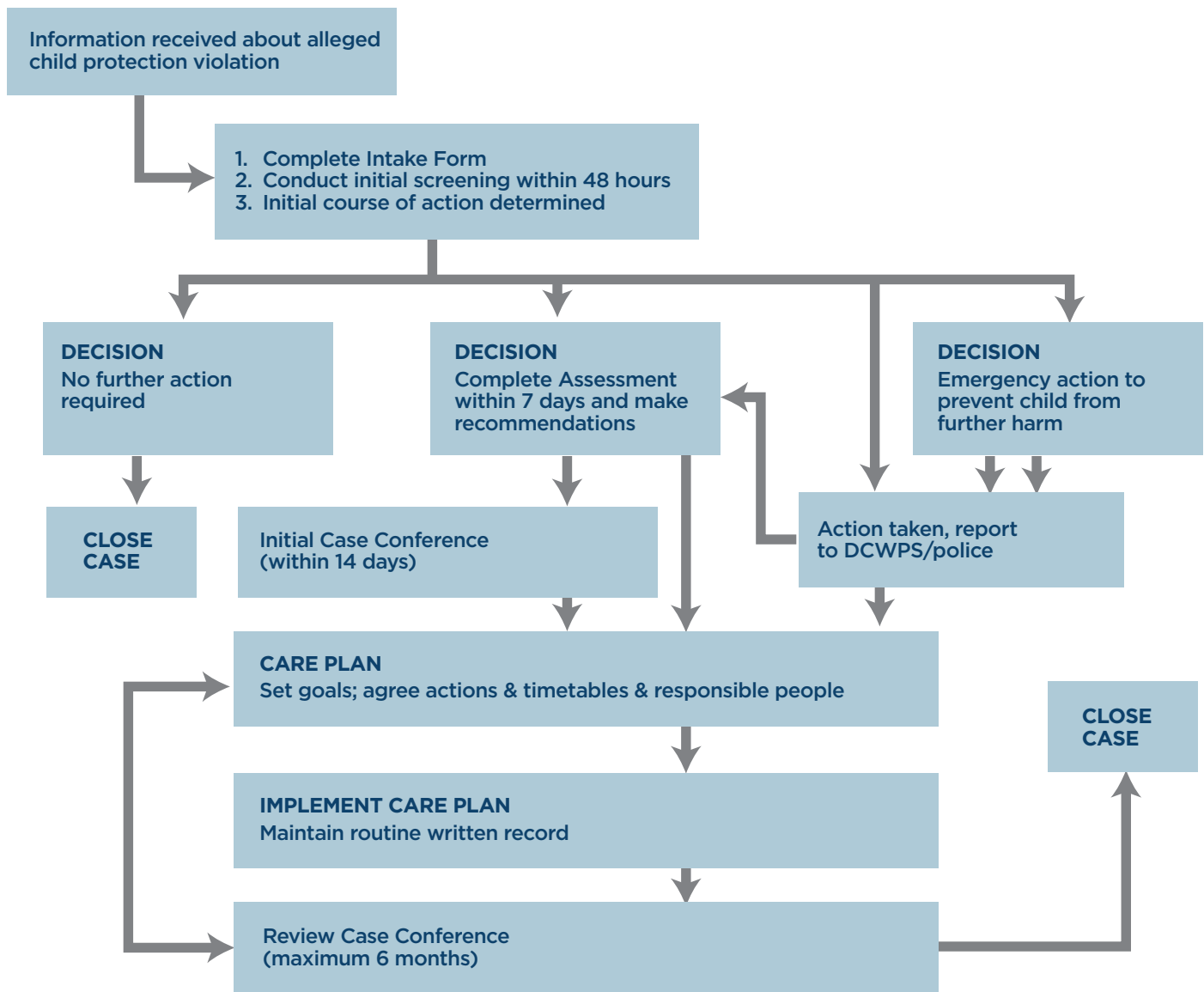
Zimbabwe National Statistics Agency, UNICEF, Center for Disease Control and Prevention and Collaborating Centre for Operational Research and Evaluation (2013). National Baseline Survey on Life Experiences of Adolescents.

Annex 2: List of key informants

NO	NAME	TITLE	ORGANIZATION
1.	Patience Ndlovu	COP	WEI/B
2.	Tsitsi Chirinda	DCOP	WEI/B
3.	Precious Muwoni	Social Protection Advisor	WEI/B
4.	Washington Jiri	National Case Management Coordinator	WEI/B
5.	Obert Darara	M&E Manager	WEI/B
6.	Janet Sibanda	M&E Officer	WEI/B
7.	John Nyathi	Acting Deputy Director	DCWPS/MPSLSW
8.	Faith Mavengere	Child Welfare Officer	DCWPS/MPSLSW
9.	Victor Ngulube	MIS Specialist	DCWPS/MPSLSW
10.	Liberty Svosve	IT Officer	DCWPS/MPSLSW
11.	Simbarashe Chihota	Case Management Officer	DCWPS/MPSLSW
12.	Aubrey Chitambire	Case Management Officer	DCWPS/MPSLSW
13.	Noriko Izumi	Chief of Child Protection	UNICEF
14.	Jeremiah Chinodya	Child Protection Officer	UNICEF
15.	Musekiwa Makwanya	Case Management Consultant	UNICEF
16.	Tapfumaneyi Kusemwa	Child Protection Specialist – Justice	UNICEF
17.	Rennie Chisvipa	Child Welfare Officer	Goromonzi DCWPS
18.	Nvasha Chevo	Case Management Officer	Goromonzi DCWPS
19.	Takudzwa Mapeza	District Social Services Officer	Goromonzi Department of Social Services
20.	Constable Mushati	Police	Goromonzi District
21.	Constable Constantino	Police	Goromonzi District
22.		Registration Officer	Goromonzi District
23.	Itai J. Maremera	Health Officer	Goromonzi District
24.	Virginia Mateta	District Administrator	Goromonzi District
25.	Mrs. F. Chakauya	Women's Affairs Officer	Goromonzi District
26.	Moses Chitiyo	Ministry of Information Officer	Goromonzi District
27.	Jane Jambaya	Child Line Case Manager	Goromonzi District
28.-38.		11 Child Care Workers	Goromonzi District
39.	Tawanda Zimhunga	Provincial Child Welfare Officer	Masvingo DCWPS
40.	Munyaradzi Nhemachena	Child Welfare Officer	Chivi District
41.	Steven Rwodzi	Case Management Officer	Chivi District
42.		Social Welfare Assistant	Chivi District
43.		Office Administrator	Chivi District
44.		District Administrator	Chivi District
45.		Field Officer – Batanai HIV and AIDS Service Organization (BHASO)	Chivi District
46.		District AIDS Coordinator (National AIDS Council)	Chivi District

NO	NAME	TITLE	ORGANIZATION
47.		Ministry of Education Representative	Chivi District
48.		HIV Prevention Community Organization	Chivi District
49.		Ministry of Youth Representative	Chivi District
50.-69.		20 members of multi-stakeholder group	Ward 18 Chivi District
70.-75.		6 female caregivers	Ward 18 Chivi District
76.	Tendai Towera	Acting Registrar	Council of Social Work
77.	Monalisa Chishato	Program Officer	Council of Social Work
78.	Kudzai Ruzvidzo	Finance Officer	Council of Social Work
79.	Stella Motsi	National Director	Child Line
80.	Jini Roby	Faculty	Brigham Young University
81.	Siân Long	Senior Associate	Maestral International

Annex 3: NCMS Case Management Process³⁶



³⁶ Ministry of Public Service, Labour and Social Welfare (2015). Operations Manual for the National Case Management System for Welfare and Protection of Children in Zimbabwe.

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.

