THE UNITED REPUBLIC OF TANZANIA

Ministry of Health, Community Development, Gender, Elderly and Children

NATIONAL INTEGRATED CASE MANAGEMENT SYSTEM FRAMEWORK

October 2017

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Abbreviations

AIDS	Auto Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CHMT	Council Health Management Teams
CHSSP	Community Health and Social Welfare Systems Strengthening Program
CJF	Community Justice Facilitators
CVAWC	Council Violence Against Women and Children Protection Committees
CSWO	Community Social Welfare Officer
CCW	Community Case Workers
CHW	Community Health Worker
CP	Child Protection
DWCPT	District Women and Child Protection Teams
ECD	Early Childhood Development
FGM	Female Genital Mutilation
GBV	Gender Based Violence
GOT	Government of Tanzania
HIC	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
ICM	Integrated Case Management
LCA	Local Council Authority
LGA	Local Government Authority
LCC	Local Council Committee
LCCW	Lead Community Case Worker
LGA	Local Government Authority
MoHCDGEC	Ministry of Health, Community Development, Gender and Children
MVC	Most Vulnerable Children
NAP	National Action Plan
NCPS	National Child Protection System
NICMS	National Integrated Case Management System
NGO	Non-governmental Organization
NPA-VAWC	National Plan of Action to End Violence Against Women and Children
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PO-RALG	President's Office – Regional Administration and Local Government
RHMT	Regional Health Management Team
RS	Regional Secretariat
RSWO	Regional Social Welfare Officers
SOP	Standard Operating Procedures
SWA	Social Welfare Assistants
SWO	Social Welfare officers
UNICEF	United Nations Children's Fund
VAC	Violence Against Children
WDC	Ward Development Committee
WEO	Ward Executive Office
WMAC	Ward Multi-Sectoral Aids Committee
WMCVV	Ward Most Vulnerable Children's Committee
WSWO	Ward Social Worker Officer

Acknowledgement

The National Integrated Case Management System (NICMS) is the output of a National Task Force comprised of members from the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) through the Social Welfare section, and the President's Office – Regional Administration and Local Government (PO-RALG). The National Task Force was chaired by the MoHCDGEC, who provided leadership and guidance. John Snow Inc. and World Education Inc. provided expert technical assistance to the National Task Force through the Community Health and Social Welfare Systems Strengthening Program (CHSSP) funded by the United States Agency for International Development (USAID) under the United States President's Emergency Plan for AIDS Relief (PEPFAR).

The NICMS aims to connect and coordinate all service providers working with children across the different sectors of HIV/health, protection, and social welfare. The framework will support the MoHCDGEC through the Social Welfare section, and PO-RALG to implement a harmonised and standardised national integrated case management system that is comprehensive and complementary to Tanzania's national policies and other legal frameworks.

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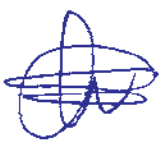

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PART I: CONCEPTUAL FRAMEWORK

This section outlines the background, rationale, key concepts, goal and objectives, guiding principles, and intended beneficiaries and implementers of the NICMS.

I. Background

There are an estimated 6.2 million Most Vulnerable Children (MVC) in Tanzania.[1] This is a significant increase from the 2011 *Projected Numbers of Most Vulnerable Children Study*, which estimated 1.67 million children in 2010 and projected an increase to 1.81 million children in 2015. The significant increase is attributed largely to population growth, especially in rural areas.

Through different policies, the Government of Tanzania has committed to improving and securing the well-being of all children and mitigating the negative impacts of HIV, poverty, orphan-hood, elderly-headed households, disability, child neglect, child early and forced marriage, and violence against children, including physical, sexual, and emotional abuse. Particularly, the following policies are of special interest:

- ***The National Costed Plan of Action for Most Vulnerable Children II*** seeks to enhance the well-being of most vulnerable children by protecting their rights and preventing and/or reducing the incidence of risk and the impact of shocks.
- ***The National Plan of Action to End Violence Against Women and Children*** envisions a Tanzania where women and children are free from all forms of violence.
- ***The Community Based Health Program*** will expand the number of community health workers and directly contribute to the goal of 90-90-90 (90% of people know their status, 90% enrolled on ART, and 90% achieving viral suppression) and will help Tanzania to achieve an AIDS free generation.

While these national policies are critical to ensuring that MVCs and victims of violence receive the vital wrap-around care and support services they need, inadequate investment in coordinating the service providers and structures that operate under these policies has led to fragmented programming, weak referral networks, and sub-optimal social welfare, protection, and HIV outcomes for children.

II. Rationale

A recent national survey on Violence Against Children (VAC) in Tanzania found that nearly one in three girls and one in six boys reported at least one experience of sexual violence prior to age 18. Two-thirds of children in Tanzania suffer from two or more severe deprivations and an estimated one in five children is engaged in child labor.[2]While most vulnerable children in Tanzania live in families, a large number do not live with both or either parent and about 10% are orphans.[3] There is evidence that children living in child-headed households and in households with ill adult caregivers

[1]Measure Evaluation, "Estimating the population of orphans and vulnerable children in Tanzania", Working Paper prepared for USAID, February 2015. The Government of Tanzania identifies vulnerable children through the MVC identification process using criteria defined in the National Costed Plan of Action for Most Vulnerable Children 2013-2017 (NCPA II).

[2]Unless otherwise noted, the statistics in this document are taken from two sources: National Bureau of Statistics (NBS) [Tanzania] and ICF Macro. 2011. Tanzania Demographic and Health Survey 2010. Dar es Salaam, Tanzania: NBS and ICF Macro; Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and ICF International 2013. *Tanzania HIV/AIDS and Malaria Indicator Survey 2011-12*. Dar es Salaam, Tanzania: TACAIDS, ZAC, NBS, OCGS, and ICF International.

[3]18% do not live with both parents, 16% do not live with either parent, and 10% are orphans (one or both parents dead).

are more likely to miss scheduled immunizations and less likely to access other child health services, leaving them susceptible to preventable childhood illnesses.

To address these issues, the Social Welfare section and the PO-RALG, with technical support from the USAID/PEPFAR- funded CHSSP, have created the National Integrated Case Management System (NICMS). This framework aims to connect and coordinate all service providers working with children across the different sectors of HIV/health, protection, and social welfare. The framework will support the Social Welfare section and PO-RALG to develop a harmonised and standardised national integrated case management system that is comprehensive and complementary to Tanzania's national policies and other legal frameworks. The system will strengthen the National Child Protection System, as well as improve efficiency and functioning of community structures by empowering them to triage cases at the community level, provide the services they are capable of and refer patients to other community and clinical structures that will need further resources.

In addition, this HIV-sensitive integrated case management framework defines qualifications, training requirements, and sets guidelines for the types of services that can be offered by each cadre in the welfare sector. The framework will contribute to strengthened bi-directional referrals among service providers and better communication across the health-protection-social welfare continuum for achieving the goal of 90-90-90.

III. Key Concepts

Below is a list of key concepts in relation to the NICMS:

Case Management: An approach used by social welfare cadres to ensure the provision of appropriate and effective multi-sectoral support services for vulnerable children and families. Case management begins when a person or family is identified as vulnerable or is in a difficult situation requiring support or assistance. Effective case management can empower families to understand and access services by creating child and family centred care plans, with the end goal of helping families gain coping skills and improve resilience, autonomy, and well-being. It includes regular checks-ins to make sure that the care plan results in the intended effect or to evaluate the need for revisions.

Integrated Case Management (ICM): An integrated case management system refers to a system, or combination of systems, able to effectively coordinate referrals and services across a wide range of government sectors, particularly protection, justice, social welfare, HIV and AIDS, health and education in order to achieve the best outcomes for children. Integration means that service providers supporting vulnerable children and families must work together to offer the range of services in a harmonised and holistic manner and are held accountable to the child and the family.

Community Case Worker/Community Volunteer (CCW): A volunteer at the community level who is willing to work in his/her community and possesses the skills to identify and connect resources to link MVC with services for care, support and protection. CCWs are trained by government employees using the training package developed by the Government of Tanzania.

Lead Community Case Worker (LCCW): A volunteer at the community level who is willing to work in his/her community and possesses the skills to identify and connect resources to link MVC with services for care, support and protection. They differ from CCWs in that they are trained as Para-Social Workers and have skills in peer supervision. LCCWs assume the coordinating role for information pertaining to cases and services provided to MVC and families through the case management system.

Most Vulnerable Children (MVC): Children under the age of 18 years falling under extreme conditions of severe deprivation, and who are unable to meet their needs for adequate education,

health care, food/nutrition, shelter, HIV/AIDS care, early childhood development (ECD), and emotional and physical protection.

Triaging: "Case categorization and prioritization" whereby trained community case workers ensure that urgent cases receive immediate attention and all protection cases are referred to professional social workers.

IV. Goal and Objectives of the NICMS

Goal: To have a harmonised, standardised, and systematic framework for the care and protection of MVC and their families that links social welfare, health/HIV, protection, and education sectors from the community to the national level.

Objectives:

- Establish ***recognized standards*** in case management to improve provision of comprehensive care for MVC
- Ensure ***comprehensive, equitable, and gender sensitive social welfare services*** are provided to MVC and their families
- ***Strengthen and integrate existing community and facility based systems*** in social welfare, protection, health, HIV, and education
- Contribute to ***HIV epidemic control*** by improving referral mechanisms between community and facility based service providers
- ***Rationalize case loads for social welfare cadres*** by defining roles and responsibilities of social welfare professionals, para-professionals, and community volunteers who work together within established parameters

V. Guiding Principles of the NICMS:

The NICMS adheres to the global principles of case management. These principles mirror local ethical practices of child protection standards and are in conformity with ethical and practice standards of different professional bodies.

Principles of Case Management

Principle	What does it mean?
Do No Harm	Ensure that actions and interventions designed to support the child (and their family) do not expose them to further harm.
Prioritise the Best Interest of the Child	The "best interests of the child" broadly refers to the child's well-being and provides the basis for all decisions and actions taken, and for the way in which service providers interact with children and their families. Any action/decision taken upon a child must be in the child's best interest.
Ensure Accountability	Accountability refers to being responsible and taking responsibility for one's actions.
Based on Sound Knowledge of Child Development & Child Rights	Assessments and interventions must be made on the basis of knowledge about child development within their family and cultural context and of child protection.
Child's Right to be Heard and Views Taken Seriously	Children have a right to be consulted and have their opinions sought and taken into account in decisions that affect their lives according to age, maturity and developmental ability.
Provide Culturally Appropriate Processes and Services	Case workers and agencies should recognize and respect diversity (for example ethnic, cultural, linguistic and religious) in the communities where they work.
Seek Informed Consent and/or Informed Assent	Informed consent is the voluntary agreement of an individual who has the capacity to give consent, and who exercises free choice. To provide "informed consent", the child must be able to understand, and take a decision regarding his own situation.
Respecting Confidentiality & Sharing Information on a Need-to-Know Basis	Confidentiality is the mandate governing sharing information on a need-to-know basis. It is the process whereby information is protected from falling into the wrong hands and ensuring it is accessible only to those authorized to access it. This means that a Community Case Worker or case manager does not share information about a client unless is it necessary to do so, for example at a case review session.
Working in a Non-Discriminatory Way	Avoid treating a child differently because of their individual characteristics or groups he belongs to (for example, sex, age, socio-economic background, race, religion, ethnicity, disability, sexual orientation, gender identity or any other diversity). This also means making sure women and girls are treated equally to men and boys.
Act with Integrity	Community Case Workers and agencies should act with integrity by not abusing their power or the trust of the child or the family. The case workers should work in collaboration with the children and families they are supporting and make sure their clients understand the process by providing them with good information. They should also listen to children and families and consider their wishes when undertaking the assessment and developing the care plan.
Family-centred Approaches	The case workers should look at children within the context of their families.

VII. Beneficiaries of the NICMS

The NICMS was specifically designed to meet multiple needs of children and is the glue that connects and binds protection, welfare, and HIV service providers through coordinated referrals. It is designed to serve any child in need of protection, welfare, or HIV services. These include the following:

- Children living in extremely poor households with significant unmet needs in terms of adequate education, health care, food/nutrition, shelter, HIV/AIDS services, ECD services, and emotional and physical protection
- Children whose sole caregiver has a disability that severely hinders the provision of care, protection, and support
- Children living in households with only an elderly caregiver (60 years and above) and with significant unmet needs in terms of adequate education, health care, food/nutrition, shelter, HIV/AIDS services ECD services, and emotional and physical protection
- Children who are orphans with significant unmet needs in terms of adequate education, health care, food/nutrition, shelter, HIV/AIDS services ECD services, and emotional and physical protection
- Children living in a household with a chronically sick caregiver with significant unmet needs in terms of adequate education, health care, food/nutrition, shelter, HIV/AIDS services ECD services, and emotional and physical protection
- Children with a disability with significant unmet needs in terms of adequate education, health care, food/nutrition, shelter, HIV/AIDS services, ECD services, and emotional and physical protection
- Children living with a chronic illness with significant unmet needs in terms of adequate education, health care, food/nutrition, shelter, HIV/AIDS services ECD services, and emotional and physical protection
- Children living with HIV or at high risk of acquiring HIV
- Children living in child-headed households
- Children living or working on the streets
- Children assessed to be at risk of, or suffering from, violence, abuse and/or neglect
- Children assessed to be at risk of, or in conflict and contact with the law
- Children living in institutional care
- Children born in prison or accompanying their mothers in prison or remand prisons
- Children involved in the worst forms of child labour (sexual exploitation, illicit activities), paid domestic work, victims of child trafficking, work that consistently interferes with school attendance.
- Children assessed to be at immediate risk for a reason not identified above, such as substance abuse, children displaced due to man-made and natural disasters (i.e. earthquakes, fires, flooding, and conflict).

Problems can be complex, and often, a child will be in need of more than one service. For example, a young girl with a protection case may also need HIV testing; or a child living with HIV may need welfare services to help her and the family make sure she adheres to ART. If, on the contrary, a child comes from a poor household, but the parents are able to feed, clothe, and educate the child, do no resort to violence, and care for her health, there is no reason for a community case worker to open a case, even if the child is on the MVC register because of poverty.

VIII. Key Implementers of the NICMS

The NICMS is a tool for social welfare cadre to solve and prevent problems that threaten the well-being of MVC and their families. The main implementers of the NICMS are the ***social welfare cadre*** and other collaborating partners both in public and private sectors, such as health, community development, education, HIV, and legal/justice. The social welfare cadre in Tanzania include professionals, para-professionals, and community volunteers. The professional social welfare cadre includes Social Welfare Officers and Social Welfare Assistants. The para-professional social welfare cadre includes Para Social Workers, while the Community Case Workers are the volunteers.

The NICMS directly supports the National Women and Child Protection System. The NICMS stipulates the roles and responsibilities of the para-professionals and community volunteers (Para Social Workers and Community Case Workers) who refer protection cases to professional Social Welfare Officers through the National Child Protection System.

The NICMS also provides guidance about how social welfare cadres at all levels (council, ward and village/mtaa) should work with other cadres in health, HIV, education, and justice/legal sectors. Social welfare cadres can refer MVC and their families to health, HIV, education, protection, and justice service providers. Equally, health, HIV, education, and legal/justice service providers can refer their clients to social welfare cadres. This collaboration and coordination is critical to ensure integrated multi-sectoral service delivery.

PART II: COORDINATING STRUCTURES FOR THE NICMS

This section describes how the NICMS links with existing structures and national policies. Each level of government (i.e. national, regional and local) plays a distinctive role to facilitate the functions of the decentralized public administration and service provision system to maintain strong and functional service delivery both at facilities and community levels, as well as reporting and supportive supervision with their lower levels.

I. Coordinating Structure

At the national level, the MoHCDGEC led the development of the NICMS through the National Task Force. PO-RALG is responsible for managing and overseeing all aspects of social welfare services provided in LGAs through the Regional Secretariats (RS). The MoHCDGEC is charged with the role of policy development, provision of technical instructions, and oversight. PO-RALG and MoHCDGEC conduct periodical support supervision to selected LGAs. The day-to-day management rests with the department responsible for social welfare services in the region or council to where the services take place.

The regional level is an important part of the administrative network in the country. The basic responsibilities of the RS include advising, coordinating and building capacity of the councils, and enabling the latter to carry out their responsibilities.[4] Regional Social Welfare Officers provide oversight to the Council Social Welfare Officers on technical performance. As a technical arm, the Regional Health Management Team, of which the Social Welfare Unit falls under, is responsible for providing oversight to the Council Health Management Teams (CHMTs), of which Council Social Welfare Section is under it. On the technical and sector specific administrative performances, the CHMT (including the Council Social Welfare Unit) is the operational body at the council level that is responsible for health and social welfare services provision. This also encompasses District Women, Children Protection Teams (DWCPTs) and the committee responsible for Most Vulnerable Children at ward level. The Social Welfare Officers/Social Welfare Assistants or assigned officer (supervisor) will provide supportive supervision and overall administrative oversight for the CCWs and LCCWs.

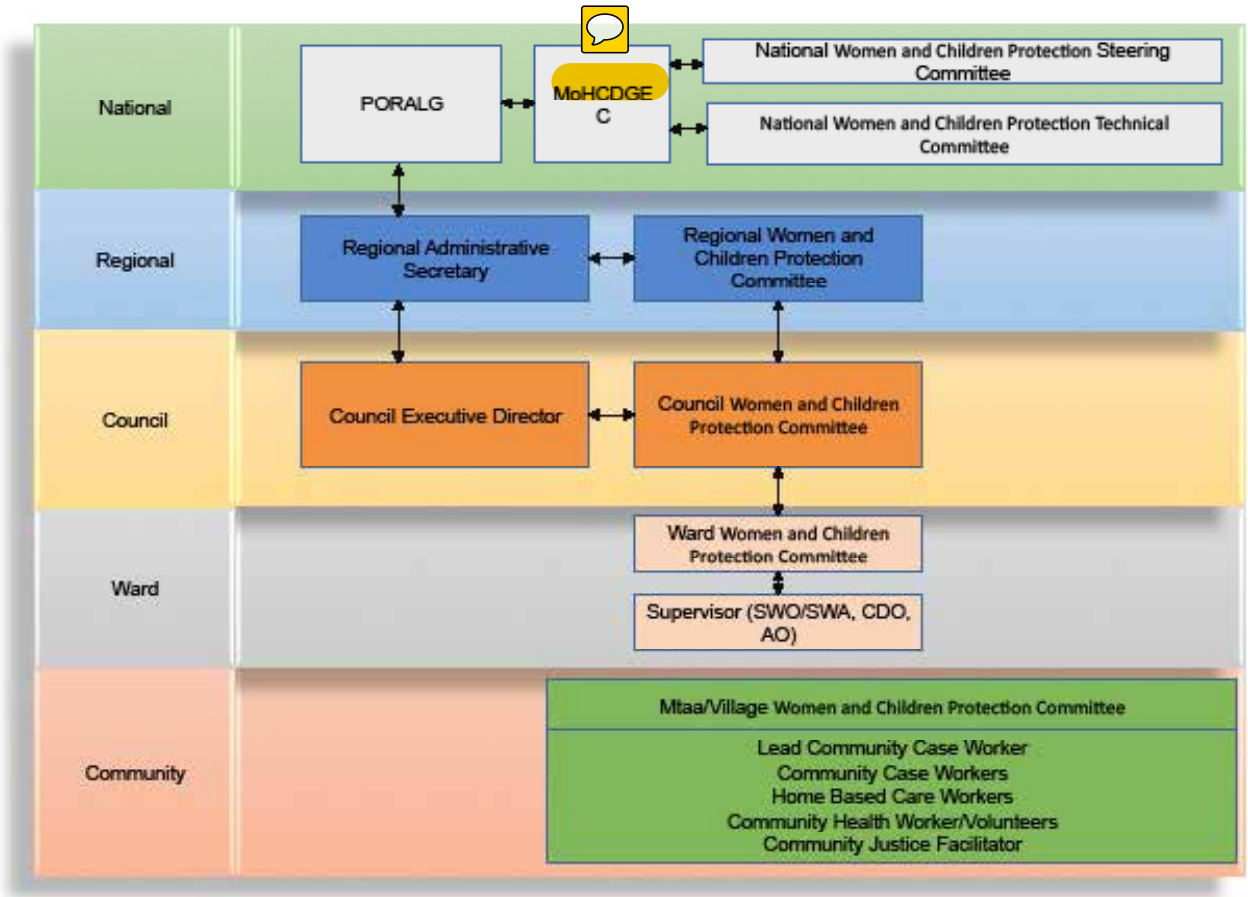
The CCWS, LCCWs, Home Based Care Volunteers, Community Health Workers (CHWs) and Community Justice Facilitators (CJF) work with the Social Welfare Officer at the community level. They are responsible for identifying, referring and linking MVC and their families with services and follow up.

At all levels of government, the service providers must report to the structures directly above them and provide oversight and support supervision to the levels directly beneath them.

[4]Circular no.8 of The Permanent Secretary PMO-RALG regarding usage and submission of information to and from the Regional Secretariats and Local Government Authorities, July 2012

Figure 1: Government coordinating structures for the NICMS

The diagram below illustrates the coordination of specific national, regional, council and community level structures working together toward the goal of quality service provision to MVC and families.



II. National Integrated Case Management System Linkages with Existing National Policies and Systems

The NICMS builds on and connects existing national policies and structures by connecting service providers from social welfare, child protection, and health and defining their roles and responsibilities in making and following up on referrals through case management.

National Plan of Action to End Violence Against Women and Children (NPA-VAWC): This five-year plan (2017/18 – 2021/22) provides a comprehensive plan of action to address violence against women and children in Tanzania. The plan builds on current strategic interventions and activities in particular response area, which is part of eight NPA-VAWC thematic areas and combines previously supported systems for women and children into one unified protection system.

National Child Protection (CP) System: This system has been developed and implemented in many types of councils in Tanzania and is incorporated into the NAP-VAWC. Although primarily focused on child protection, the CP system provides an entry point for identification and cross referral of cases from the child protection system to the NICMS for broader welfare issues, and vice versa, from the NICMS to the CP system for protection cases. Many of the protection risks that children face place them at direct and indirect risk of exposure to HIV or worsened HIV outcomes. These include transactional and "forced" sex or early marriage, school dropout and contact with the law. In order to ensure that children's multiple vulnerabilities are addressed, these two systems must work in collaboration.

Health System: To ensure HIV sensitivity and enhanced health outcomes, CCWs and LCCWs are required to work in collaboration with existing health systems. With the ambitious 90-90-90 targets, the integrated case management system recognizes the need to pay particular attention to HIV infected and affected children. Like all vulnerable population groups, MVCs with HIV struggle to access basic services such as health services, HIV testing and counselling (HTC) and antiretroviral therapy (ART), education, adequate food, as well as shelter and psychosocial support. These services take on increased importance for children living with HIV: effective treatment of HIV requires food to accompany ARVs and good nutrition; psychosocial support is needed to address issues of living with a chronic illness, coping with stigma and discrimination and many other related issues. Linking with health community providers and facilities, caseworkers will complete the loop of comprehensive support by providing important wraparound services, such as education, psychosocial guidance to enhance child protection, all of which are crucial for epidemic control.

National Costed Plan of Action for Most Vulnerable Children (NCPA II 2013-2017): The goal of the NCPA II is to enable a multi-sectoral, government-led and community driven MVC response system. This constitutes a commitment to facilitate adequate MVC care, support, protection and access to basic social services. The integrated case management system will advance the objectives of the NCPA II by localizing the response at the community level and strengthen the skills of existing members of committees responsible to identify and coordinate services for vulnerable children and women.

PART III: CASE MANAGEMENT PROCESS

This section outlines the steps needed to be taken in case management, as well as the case management cycle.

I. Case Management Steps

Step	Definition and Key Decision/Action Points	National Forms	National Tools	What Happens During this Step
Step 1: Intake	Intake begins when someone notices a potential protection, health, or social welfare concern and brings it to the attention the CCW or LCCW. Anyone can notice a potential concern. It can be the LCCW or the CCW, a member of the Women and Children Protection Committee, a neighbour, village leader, teacher or any concerned community member. Intake is the first step in the process of addressing a concern. (Annex 2 – Intake Form for Social Welfare Officers) ***Key questions: Should the CCW refer to the Women and Children Protection Committee? Open a case? Or call the SWO?***	National MVC and Household Registration Form	Registration Job Aid Protection Triaging Job Aid HIV Risk Triaging Job Aid	When a concern about a child comes to the attention of the CCW, there are three possible courses of action: 1. The CCW decides it is possible to resolve the concern immediately without opening a case. He/she resolves the concern, fills out the National Registration Form, and does not open a case. The CCW may refer the child to the Women and Children Protection Committee for further assistance. 2. The CCW decides that he/she needs to open a case to start resolving the concern. He/she fills out the National Registration Form, opens a case, and proceeds to step 2 – assessment. 3. The CCW realizes this is a protection issue. He/she calls the Social Welfare Officer (and if necessary the Gender and Child Desk Police), The SWO opens a case and registers the child in the National Child Protection System. The protection case is managed by the SWO, not the CCW. However, the SWO may call upon the CCW for assistance.
Step 2: Assessment	The "**assessment"** is the way that the CCW learns more about the situation of the child and the family so that they can develop a care plan. The assessment explores both the strengths/resources of the		Child Assessment Job Aid	The CCW conducts the assessment to learn more about the situation of the child and the family. This involves talking with the child and the caregiver, as well as other individuals who may be involved with the family.

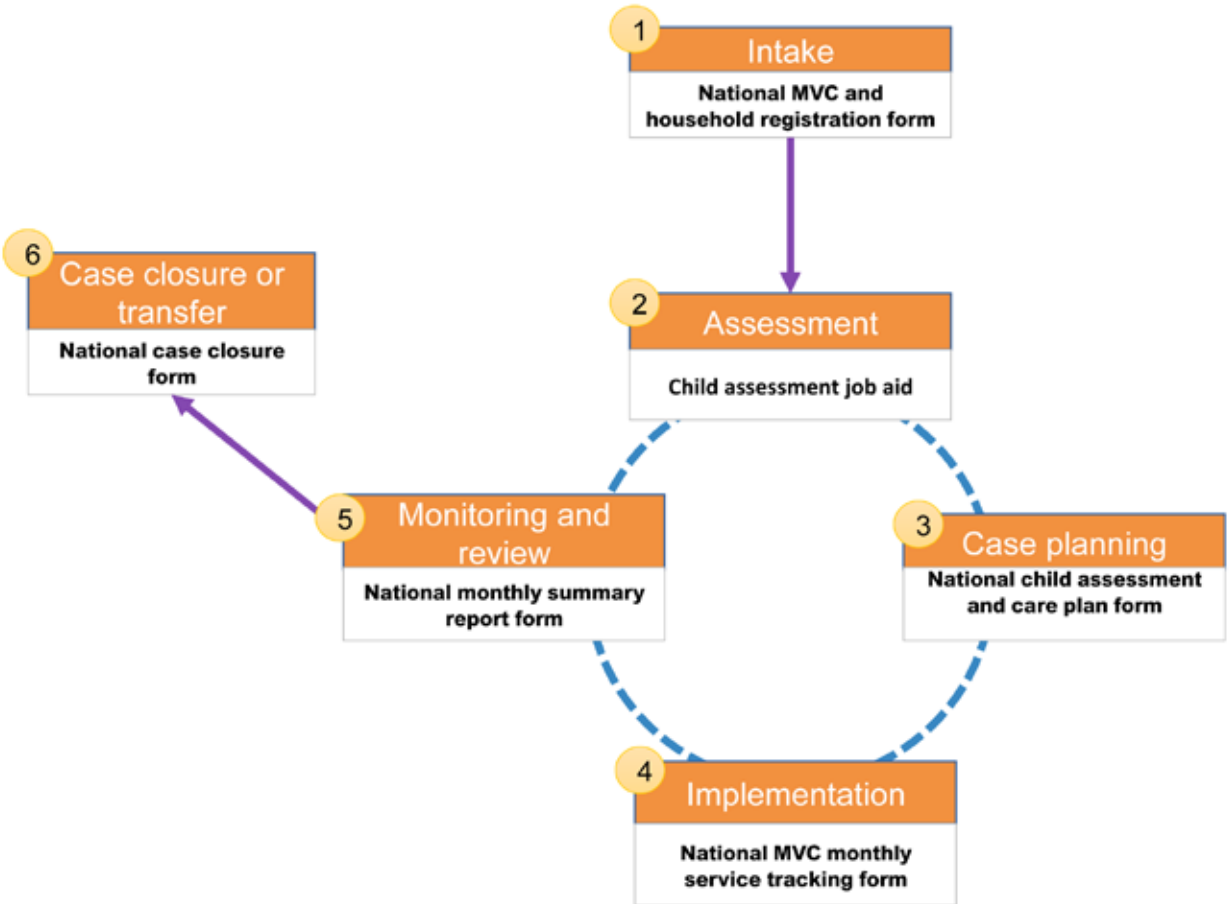
	child and family, as well as their needs. ***Key questions: What are the strengths and resources of the child and the family? What are the challenges?***			
Step 3: Developing a care plan	Developing a care plan that outlines the services and referrals the child and his/her family will receive. ***Key questions: What services does the child and the family need? Where are those services located? How can the child or family access them?***	National Child Assessment and Care Plan Form	Service Mapping Job Aid[5] Local Service Directory[6]	The CCW develops a care plan. After the care plan is developed, the CCW talks to both the child and the family to make sure they have accurate information and understand what is supposed to happen next.
Step 4: Implementing the care plan	The CCW implements the care plan. Referrals are managed in collaboration with the relevant service providers and community case workers. ***Key actions: Visit the child and family regularly to support them as needed to access services.***	National MVC Monthly Service Tracking Form	Service Mapping Job Aid Local Service Directory	During the implementation of the care plan, the CCW tries to make sure that the child and the family access all the services in the care plan. Implementation includes both services that the CCW can provide directly like home visits, psychosocial support, as well as referrals for other services at a health clinic, referral to join a savings group, parenting skills, etc. The CCW uses their service directory when making referrals. The service directory should always be up to date so that the CCW is providing accurate information to the family. During the implementation, the CCW will continue to visit the child and the family. Depending on the level of concern, the CCW may visit a few times a week, or a few times a month. The CCW records their visits in the National Monthly Tracking Form.
Step 5: Monitoring	Monitoring and Review includes periodic review	National Monthly	Case Review	CCWs meet to discuss and review their cases together with

[5] This job aid is available only in Kiswahili.
[6]This is a tool that is created, used, and updated by the CCWs.

and review	of the child's care plan through monthly case review sessions. ***Key questions: Is the situation of the child and their family improving?***	Summary Report Form	Sessions	the LCCW. CCWs can help each other to decide if the care plan needs to be adjusted, or if additional services or actions are required.
Step 6: Case closure	Case closure happens when the review concludes that all issues of concern regarding the child's welfare have been addressed or a case has been moved to another location or a child has passed away. ***Key question: Has the case plan goal been met?***	National Case Closure Form	Case Review Sessions	During a case review session, if the CCWs and LCCW feel that the concerns of the child and the family have been addressed, the case can be closed.

Figure 2: Steps in the case management cycle

The diagram below provides a graphic overview of the six steps in the case management cycle and the respective forms. Steps 4 and 5, implementation and monitoring and review are iterative, meaning they should be repeated continually until case closure.



PART IV: STANDARD OPERATING PROCEDURES

This section contains standard operating procedures (SOP) to guide the implementation of the NICMS through the six steps of case management.

SOP 1: Case Categorization

Most Vulnerable Children cases can be categorized as protection or welfare. Protection cases are those cases for which there is a legal violation and reporting is mandated. All protection cases must be reported, referred and documented within a 24-hour period to the Social Welfare Officer, hospital or the police (e.g. violence, abuse, neglect and exploitation). Welfare cases are serious cases that infringe the child's wellbeing, though there might not be imminent danger to the child's life or legal implications. An example may be a child living with HIV, neglected/abandoned and living with disabilities and lacking adequate psychosocial support, coping mechanism, scholastic materials, adequate food and nutrition, and/or a birth registration. The child may also be in conflict with the law.

The nature/category of the case will determine the risk levels and timeframe needed for response. The table below illustrates risk levels, how risks are measured and appropriate timeframes for intervention.

Level	Definition	Description	Timeframe	Examples
High risk*	Child is in life-threatening danger or in danger of suffering serious harm to the extent that his development and wellbeing is likely to be affected unless urgent steps are taken.	Child needs urgent medical or legal attention, is likely to be seriously harmed or injured, subjected to immediate and on-going sexual abuse, be permanently disabled, trafficked or will die if left in his present circumstances without protective interventions.	Interventions should take place immediately, ideally before leaving the child. Report immediately to CSWO, police and nearby health facility, Ward Executive Office (WEO) or call National Child Help Line (116).	• Child marriages • Sexual abuse • Physical abuse • HIV+ child defaulted on medication and very ill • Children living outside the family environment • FGM/C • Poor adherence to ART • Child labour
Medium risk*	A child is likely to be or is suffering some degree of harm without an effective protective intervention plan.	Intervention is warranted. However, there is no evidence that the child is at risk of imminent serious injury or death.	Report within 24 hours and services should be provided within 72 hours.	• Neglect that will interfere with development if not attended to but not life threatening • Emotional abuse • Chronic illness,

				developmental delays or disabilities not being properly attended to
Low risk	The child is not currently suffering harm, or if this is occurring, its impact is minimal, although there are indications that without appropriate care and support the child will suffer.	The home is safe for children. However, there are concerns about the possibilities for a child to be at risk if services are not provided to prevent the need for protective intervention.	Interventions should commence within 14 days.	• Out of school • Lack of Birth registration • Excessive household chores interfering with developmental - appropriate activities • Need for school fees, school uniforms • Need for routine health care

**All protection cases should be treated as high or medium risk, depending on the immediate risk posed to the child. If the child is at risk of further immediate harm, the high-risk guidelines should be followed.*

Regardless if the case is a protection or welfare case, or if it is high, medium or low risk, it is the responsibility of every child protection and social welfare invididual to ensure that no child is needlessly exposed to the risk of acquiring HIV, and that no child living with HIV is denied his right to HIV testing, treatment, care and the support necessary to live a full and healthy life.

SOP 2: Opening a Case – When and How

The CCW must complete a MVC and Household Registration Form (Annex I). Completion of this form helps the CCW determine whether to open a case immediately or not to open a case, and enrols a child in the NICMS. This form, documents decisions made based on initial screening as to whether or not a case needs to be opened. Cases must be referred to the Community Social Welfare Officer (CSWO) for immediate response in the event of protection cases, or to other service providers for welfare cases.

SOP 3: Using an Assessment Tool to Develop a Care Plan – When and How

CCWs should use the CCW assessment tool to inform the development of the care plan. The CCWs assessment tool was designed to be simple and streamlined for use by CCWs.

Assessment Process

The assessment of a child is comprehensive and family-centred and should use the national assessment tools included in annexes. The assessment collects information about the child and her family in order to get a full picture of her life circumstances and all welfare, health, education and protection issues so that the CCW can develop an appropriate care plan. The assessment gathers

information about the basic needs of the child, as well as her strengths, across eight domains– families, survival, general health, development, social history, behaviour, education and aspirations. A comprehensive assessment entails asking questions to understand all of these domains, regardless of the presenting problem or obvious area of concern.

The assessment looks at the family's relationships and how well the child's family (parents and extended family or other recognized primary caregivers) can look after her. The assessment should gather information from as many relevant people/sources as possible including the child, family members, involved neighbours, community leaders, influential leaders, religious leaders and other agencies such as education and health as deemed appropriate based on the situation of the child, family and primary concern (Annex 3 – Child Assessment and Care Plan Form for Community Case Workers).

By utilizing a thorough assessment, the needs and strengths of the child and family are identified and CCWs are able to prioritize concerns that need to be addressed in the care. The issues needing attention may or may not be directly related to the presenting or primary problem.

Developing a Care Plan

The care plan defines what action will be taken in order to address all areas of concern. It clearly states:

- What
- Who
- How
- When

Developing a comprehensive care plan requires taking a multi-sectoral view of issues and involving all appropriate parties in the provision of care to make sure the child's needs are met and that optimal health, wellbeing and development are supported (Annex 4 – Assessment Form for Social Welfare Officer).

SOP 4: Making Referrals – When and How

Implementation of the care plan will include direct service provision as well as strategic referrals to other service providers to link the child to all the services they require. These referrals can take place at any point in the case management process, but must be relevant to the needs of the child and family as identified in the assessment and detailed in the care plan.

Referrals and linkages between service providers are the cornerstone to case management as they enable multi-sectoral and comprehensive care. Referrals must be made with the child and family's knowledge and consent. It is the responsibility of the case worker to follow-up and make sure that the care plan is being implemented and that referrals result in service provision for the child. All contact with the child and family must be recorded on the monthly service delivery tracking form (Annex 7).

If the developed care plan is being implemented but the child's condition or situation is not changing in ways that are expected, a case conference should be called. This conference provides an opportunity for all involved parties, along with the caregiver and child, to come together and discuss the relevant issues, care being provided, barriers to improvement and different or additional care

that is needed. This may not be done at the time of a care plan scheduled review, but rather, is instituted in response to the child's or family's needs.

Figure 3: Process of care in the NICMS from referral to case closure

The diagram below shows the process of care of the NICMS from start to end.

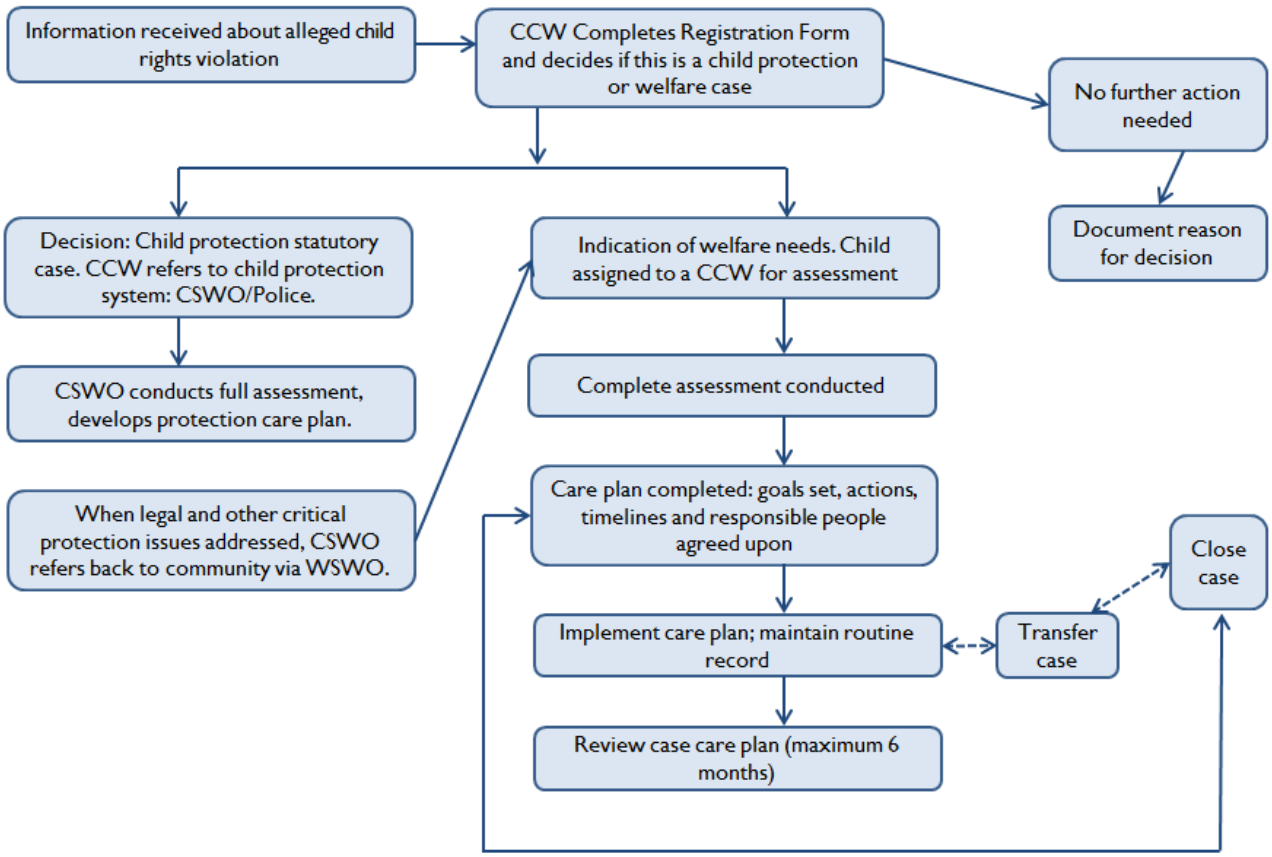
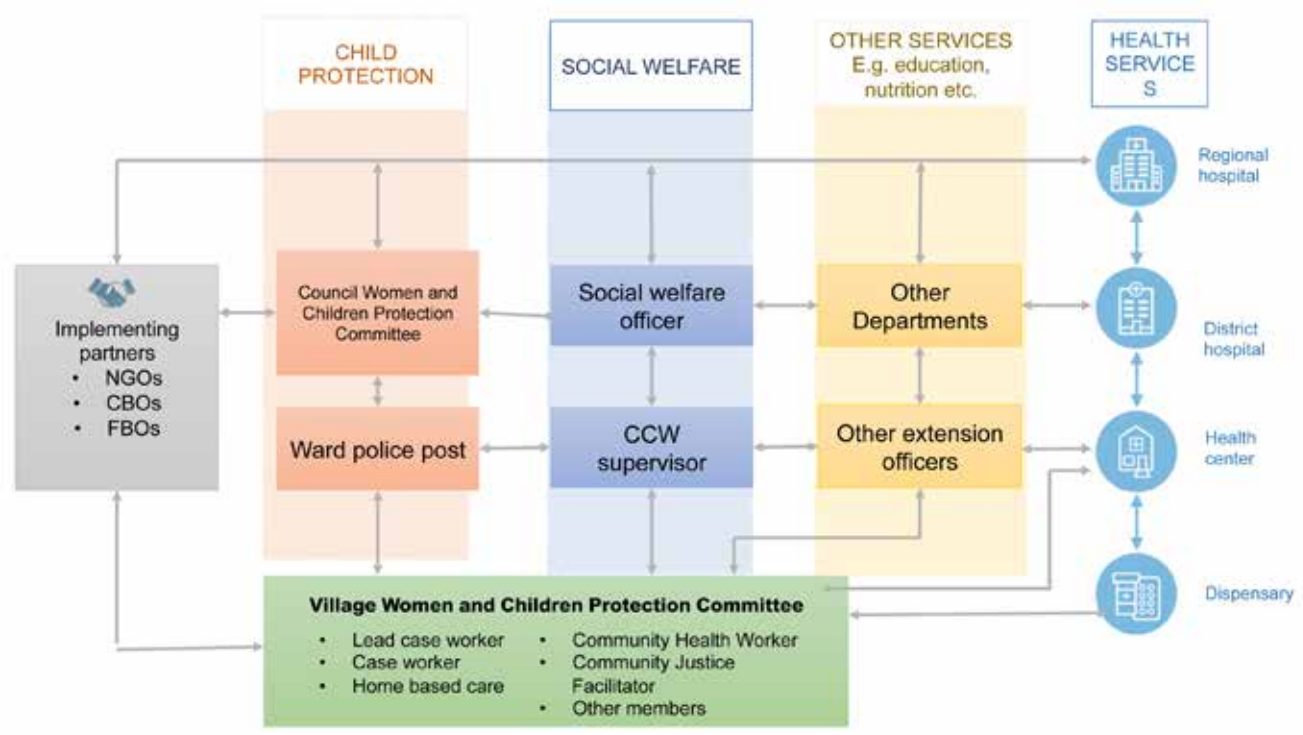


Figure 4: Referral Linkage Pathways



The figure below shows all of the referral pathways.

A referral is made when a child's need is not adequately addressed by service providers already involved with the child. Referral, therefore, link children and families to appropriate service providers and must be made with the consent of the child or caregiver, except when serious protection issues are identified. In serious protection cases, it may be necessary to override the wishes of caregiver or child if they are resistant to care that is in the best interest of the child. Depending on the nature and severity of the case, the child's needs will either be addressed at the community level, such as the dispensary or school, and/or referred to other service providers such as the CSWO, health centre, NGOs, or CSOs operating in the locality that offers services in line with the needs identified on the care plan. Women and Children Protection Committee members should identify referral focal persons at health facilities and other organizations to facilitate the referral process.

It is the responsibility of the CCW, or other professional (SWO) coordinating the case to ensure that:

- A service provider is identified for all needed interventions identified on the care plan.
- A referral form is completed to make the connection between the child and family and the service provider.
- The referral form is received and accepted by the service providers the child is being referred to.

- Information is received regarding the outcome of the appointment, meeting, or intervention and the plan is made between that provider and the child/family if intervention is on-going. The CCW should make sure that this happens.

Referral pathways include formal referrals between the government structures within the Social Welfare section, (between the CSWO and the Women and Children Protection Committee) and those that are between the government structures and implementing partners (between the Women and Children Protection Committee and NGOs). All serious child protection case referrals should be centrally handled by the CSWO (central case manager). The CSWO will coordinate all services provided by the Women and Children Protection Committee and specialist agencies if more follow-up is needed for statutory issues.

A referral form (Annex 5 – Referral Form for Community Case Workers) should always have a mechanism like a tear off slip or duplicate copy, which enables both the referrer and the recipient of the referral to maintain a copy of the original referral, and to communicate receipt and acceptance of the referral.

Follow-up

When a referral is made to a service provider, it is essential that there is follow-up and feedback. The respective responsibilities of the CCW and the care provider are as follows:

- The CCW follows up to be sure that the service provider acts on the referral and meets with the child or family
- The service provider receiving the referral not only acts on the referral, but gives feedback to the CCW about the action taken with the referral and the plan for moving forward

Both of these steps are important to ensure well-coordinated care to the child in need. Regardless of the method by which the feedback is given, whether verbal or written, it must be documented in the case record. It is the CCWs responsibility to ensure that the referral feedback loop is completed for all referrals made.

SOP 5: Service Mapping for Case Management

The SWOs at the council level and ward level should facilitate service mapping. Service mapping serves the purpose of compiling a directory of resources and service providers available to address the range of needs faced by MVC. The service mapping exercise identifies the informal and formal community resources or structures that can support child protection and welfare services.

Service mapping should be conducted at the village/mtaa level and compiled at the ward level, where the ward service mapping should also be added. Service mapping is a basic process of listing name, contact information and description of services offered by all providers in a community. After community level services have been added, the directory can be moved up to the council level for additions of council level resources and compiled into a centralized directory to enable ease of access to resources.

Despite the background of the multifaceted challenges faced by children, the community remains a crucial source of potential support since it includes friends, neighbours, traditional leaders, elders, teachers, youth groups and religious leaders who can provide care to children. It is critical that these informal sources of support are drawn on in the provision of services.

SOP 6: Case Review Sessions

Case Review

The review is a process of checking that the child's care plan is on track and is meeting the child's needs. It provides an opportunity to reflect on how the implementation of the plan is progressing, to consider (together with the assessment) whether the plan remains relevant; and if not, to make the necessary adjustments to the plan which should be documented in the care plan. The nature of the case should determine the frequency of the case review, but at a minimum, a formal review should be conducted every six months.

Village/Mtaa Monthly Case Review Sessions

The monthly case review session is an important part of implementing a care plan. The monthly case review session is coordinated by the LCCW and brings together involved stakeholders to consult on and discuss the details of a case and make decisions on actions that need to be taken to safeguard the welfare and protection of a child. It is also an opportunity for the CCW to get supportive supervision and input from peers and LCCWs on complicated cases or difficult decisions. A child's case should be discussed at a monthly case review session when first enrolled in the NICMS and when needs are complex and/or there are multiple providers with potentially valuable input into the development of the care plan, or multiple needs that may benefit from involvement by multiple stakeholders in the care plan. Depending on local resources and availability, the monthly case review session can take place at the local health facility (dispensary or health clinic), the office of the Village/Mtaa Executive Officer, or other community structures.

Regardless of the location of the monthly case review session, it is important that the local health facility designates a clinical HIV focal person to participate in the meetings to facilitate bi-directional referrals between the community based cadres and facility based cadres. The regular and active participation of the clinical HIV focal person has the following benefits:

- Community case workers who referred clients for HIV testing and counselling through the HIV testing screening tool can follow up with HIV service providers to ensure their clients access HIV services.
- HIV service providers can refer their clients to Community Case Workers for wrap around social services.
- Community Case Workers are able to identify and enrol HIV clients who were previously lost to follow up.
- Provides a regular forum for community and facility based health/HIV providers to share information about cases and ensure referral completion.
- Community Case Workers, Community Health Workers, and facility-based health/HIV providers work together as a team to ensure referral completion and identify and re-enrol clients who were previously lost to follow-up.
- Facilitates referrals made from community to schools, other organizations and service providers and from schools, organization/service providers to the community, originating wherever and whenever a concern is identified.
- Removal of barriers that prevent sharing information between social services and health providers to ensure comprehensive wrap around care.
- Structured relationship building and information sharing through regular meetings.

- A system for structured follow-up on all referrals to ensure completion of the referral process.

Ward Level Case Review Sessions

On the ward level a multi-stakeholder meeting is held monthly for the purpose of discussing each of the complex cases that have been identified in the communities that need further assistance. These ward level case review sessions are convened by the WSWO/SWA and include stakeholders who are involved in child welfare and protection, including police, health providers, LCCWs and other relevant stakeholders. Summaries of cases identified at the village level case conference as needing multi-sectoral input are brought by the LCCWs from village/mtaa and are presented for discussion, recommendations and plans for action, including referrals and actions to be taken by any of the stakeholders.

Participants at the case conference are there on an invitational basis and agree to uphold the principle of confidentiality. The WSWO/SWA reports cases discussed to the CSWO. Additionally, recommendations and plans for a case that are made at the case conference are brought back to the village level by the LCCW and discussed with the CCW, family and other involved parties, such as a health worker at the local health facility. It is the CCW's responsibility to ensure that the new plans are carried out. Activities that were agreed upon by any of the stakeholders can be reviewed at the following month's conference.

In the event of concerns over a child or circumstances that warrant attention by a multi-stakeholder group sooner than the next scheduled monthly meeting, a special meeting can be convened.

The ward level case review sessions should be held at either the Ward Executive Offices, local health facility, or other community structures. A clinical HIV focal person from the ward level health facility should be designated to attend.

SOP 7: Confidentiality

CCWs ask many questions and gather information on the situation of a child or a family so that they can help them to solve their problems. CCWs should always respect confidentiality. This means that a community case worker or case manager does not share information about a client unless is it necessary to do so, for example at a case review session.

Confidentiality is very important when CCWs are working with cases of sexual abuse, HIV positive children, or if a caregiver is HIV positive. CCWs will be required to sign the confidentiality code of conduct form.

SOP 8: Community-Facility-School Linkages

Under the NICMS, CCWs will establish relationships with specific key institutions or organizations such as health facilities, CSOs and schools. Having individual CCWs connecting with dispensaries, schools and other specific organizations promotes relationship building that will enhance their role as a community resource and establishes them as the person to whom to refer children or to contact for concerns about potential vulnerability that needs to be investigated. Specifically, a CCW should be linked with the local dispensary to ensure relationship building and referrals from the dispensary to the village/mtaa Women and Children Protection Committee for assessment and potential enrolment in the case management system of any MVC diagnosed with HIV.

SOP 9: Case Transfer – When and How

There are times when a child's needs are best served by transferring the case to another office or organization. If it happens that the child originate from another locality and the assessment results indicate that the best interest of the child will be met easy if the case will be transferred to the original place where the child comes from, that means the particular case will be transferred. In this case, it means that the responsibility of the case, including the documentation, is moved to the other agency. The transfer should be:

- Discussed and agreed upon between the case management team, the child, and the family.
- Clearly documented in the case file.
- Coordinated between the lead organization terminating care and the one picking up the case. This coordination includes discussion with the new organization and handover of all relevant information from the case file to ensure smooth transfer of care.
- When the transfer has been made, the case is closed within the NICMS, though services to the child will continue.

SOP 10: Case Closure – When and How

Case Closure (Termination)

A case is closed at the point at which work with the child ends. The reason for ending can be due to the following:

- The care plan has been completed when the child's needs have been met, problems have been resolved and the child and family no longer require support; or services to address ongoing issues identified on the care plan are in place
- Child moves out of the area and cannot be located despite significant efforts
- Child becomes 18 years old (the case is closed unless there are good reasons to remain involved, such as additional vulnerabilities). When the case is being terminated due to age, an exit plan that includes transferring the adolescent to adult services should be in place, with the understanding and agreement of the individual.
- Child dies

The decision to close the case must be recorded in the care plan, including the reasons and the person who authorized case closure. In cases other than those where the child is no longer present, the decision to close the case should be made in collaboration with the child, and approved by the WSWO/SWA (Annex 8 - Case Closure Form).

SOP 11: Documentation, Record Keeping, and Reporting

The success of a case management system is highly dependent on the accuracy and depth of information collected about the client at each stage of the case management process. The NICMS will interface with the MIS of the government, feeding data into the national system.

For every child, an official case file will be opened using a file with a clearly marked case number. Each file should detail the client's case from their initial assessment to the present date. Case files should be kept at the village level under the custody of the Village Executive Officer, locked up and in good condition at all times. The exception is when a case involves a protection offence and is

being handled at the council level. In this circumstance, the file is kept at the council level. When a protection case being handled at the council level is simultaneously referred back to the community, a temporary file can be opened using the same file and case number. When the protection case is closed, the records can be merged and kept at the village level where care is active and ongoing.

Reporting

The flow of information about cases being served is essential to the function of the case management system. This information is captured, analysed and synthesised at each level of the system. At the village level, with support from the LCCW, the CCW prepares a monthly report on the cases for which they are providing care. The LCCW collects all reports from CCWs, compiles and submits them to their supervisor at the ward level who will, in turn, compile these and send them to the CSWO. The CSWO will then compile reports from all WSWOs in their jurisdiction and send the compiled report to the RSWO. Finally, after review of the reports, the RSWO submits the final report to PO-RALG and a copy to the technical ministry (Social Welfare section) and implementing partners.

SOP 12: Guidelines for Recruiting CCWs and LCCWs

CCWs and LCCWs are recruited from the community. They are chosen for their involvement and commitment to children. It is important that the NICMS, specifically the ward level supervisor, keeps a file on each CCW/LCCW that documents their vetting and appropriateness for their position. The file should include:

- Police clearance documenting that there has been no past evidence of the CCW/LCCW posing any danger to children.
- Documentation of completion of the CCW/LCCW training.
- Ongoing documentation of regular involvement of the CCW/LCCW in peer supervision groups. This documentation should attest to the CCW/LCCW's attendance, performance on cases and reliability regarding monthly reporting.

SOP 13: Working Tools for CCWs and LCCWs

LCCWs and CCWs along with other members of the village/mtaa Women and Children Protection Committee are volunteers and receive no monetary incentives. Each will be equipped with relevant forms and items that assist in their work. These include a name badges, hats or T- shirts.

SOP 14: Recommended Case Load for CCWs

As the community volunteer extension arm of the Social Welfare section, CCWs increase the reach of the Social Welfare section to MVC in a village/mtaa and reduce the workload of the SWO/SWA and CSWO by managing non-protection or none emergency cases within the community. The maximum case load of a CCW is 20 MVC at any given time. While time required of a CCW/LCCW will vary depending on the nature of the cases they are serving, the commitment is estimated to be approximately 8 hours per week. Number of CCWs to be trained will be determined using the ratio of 1 CCW to 20 MVC, and estimating the number of MVCs likely to need services depending on the issues and challenges of a community.

PART V: ROLES AND RESPONSIBILITIES OF GOVERNMENT AND KEY STAKEHOLDERS

This section describes the roles and responsibilities of the government and key stakeholders in the implementation of the NICMS. The NICMS is intended to benefit MVC and their families.

I. Village/Mtaa Level

Community Case Workers (CCWs)

The Community Case Workers are the frontline community workers within the framework. Their roles include but are not limited to:

- Identifying child welfare and protection cases using community-based platforms.
- Conducting intake screening for children and families for whom there is reason for concern.
- Reporting all cases of suspected abuse and any other protection offence immediately to the CSWO and/or the police in the event of emergency or if the CSWO is not readily available
- Reporting cases to LCCW.
- Conducting assessment, developing a care plan in collaboration with the child and family, making and following-up on referrals, providing support, monitoring progress, closing cases when appropriate.
- Supporting vulnerable children and families to access basic services.
- Coordinating and communicating information between providers across sectors.
- Keeping records of children and families enrolled in case management.
- Advocating for the children's welfare and protection matters to the community.
- Preparing the implementation report and submitting to the LCCW monthly.
- Referring and linking cases to other relevant authorities/institutions for further interventions.
- Mapping resources at their localities.

Lead Community Case Worker (LCCW)

Lead Community Case Workers are volunteers at the community level who are willing to do voluntary work in their communities, and are able to identify and connect with resources that can link MVC with needed services for care, support and protection. LCCWs perform all above mentioned responsibilities of the CCW, but the LCCW assumes the coordinating role of the CCWs. Additional responsibilities include:

- Ensuring that all identified cases are screened for intake and appropriately reported to the CSWO/police if a protection offense is suspected. If a protection offense is not suspected and the case can be handled at the community level, the LCCW ensures that the case is assigned to a CCW to meet the child's for welfare and health needs.
- Facilitating monthly peer to peer supervision groups with CCWs.
- Ensuring care plans are being implemented, including completion of referrals.
- Compiling and reporting all case information from CCWs to the WSWO/SWA on a monthly basis.
- Reporting all concerns regarding cases and the functioning of CCWs to the ward supervisor.

Village/Mtaa Women and Children Protection Committees

The **Women and Children Protection Committee** is the committee comprised of the community members with different potentials who can provide case management services in the village/mtaa. As such, this committee serves as the central place for community response to the needs of women, MVC and their families in the community. Besides responsibilities of the committee members, additional protection responsibilities include:

- Coordinating, supporting, monitoring and ensuring implementation of all activities related to case management in the community.
- Providing referrals of the child protection issues to the relevant Child Protection and Welfare structures.
- Conducting village/mtaa level awareness-raising and advocacy concerning child rights, stigma reduction and resource mobilization.
- Providing a link to other statutory committees and implementing partners.
- Serving as the entry point for any implementing partner working with women, MVC and families within the village/mtaa.
- Play a vital role of ensuring that MVC issues are included within the village plans.

Health Facilities and Health Professionals (Village, Ward and Council levels)

Clinics/health centre:

- Screen children with social and health issues and refer them to relevant services including provision of Post Exposure Prophylaxis (PEP) as required.
- Enrol children who are HIV positive into medication/ART.
- Refer children for adherence support.
- Address lost-to-follow up issues for MVCs who are HIV positive.

Health care workers/volunteers in a community are involved with children and families and can provide both information and services. The roles of medical and mental health providers in child protection and welfare services include:

- Providing free emergency medical treatment and services for survivors/victims of abuse.
- Providing emergency treatment and referring the abused survivors to the Police Gender and Children Desk and to Social Welfare Officer as necessary.
- Screening and assessing children visiting healthcare facilities, including emergency, as well as routine visits, for signs of harm caused by violence.
- Notify CSWO of the presence of abandoned children within their facilities.
- Providing medical and psychological treatment of abused children.
- Providing medical, social and psychological perspective in assessment and care planning.
- Providing medical examination reports for abuse cases and if required present it to court.
- Putting in place a plan/mechanism for health exemptions for MVC.
- Collecting data/information on VAC and GBV cases and disseminate the same to various stakeholders.
- Helping parents/caregivers to support HIV+ children to adhere to treatment and their own treatment, if HIV positive.

Implementing partners

These are NGOs, CBOs, FBOs which are working with the government. Their major roles and responsibilities will include, but not limited to resource mobilization and service provision.

II. Ward Level

Supervisors for LCCW/CCWs (Social Welfare Officer/Assistant Welfare Officers/Assigned Officers)

These are normally government employees at ward level (Ward Social Welfare Officer, Social Welfare Assistant). If there are no SWOs or SWAs in a ward, other extension officers can be trained as supervisors. A CCW's supervisor manages a group of caseworkers from the village/mtaa. The supervisors are trained to provide supportive supervision and overall administrative oversight for the case workers.

Supervisors at ward level are the direct link between the community and council Social Welfare Officer. The specific roles and responsibilities include:

- Providing direct support and mentorship to LCCWs in the villages, and support to the CCWs through the LCCW.
- Receiving referrals from the community level and referring to other service providers.
- Coordinating service providers at ward level.
- Conducting monitoring and evaluation for community case worker activities.
- Compiling and presenting the summary sheet of cases at monthly child welfare and protection meetings.
- Producing and sending monthly case management reports to the Council Social Welfare Officer.
- Coordinating resource mobilization at ward level to support MVC.

Ward Women and Children Protection Committees

The overall roles and responsibilities of the committee will include but are not limited to the following:

- Coordinating, supporting, monitoring and ensuring implementation of activities related to provision of care, support and protection of children at ward level.
- Providing a forum for engagement and information sharing from the village/mtaa Women and Children Protection Committees.
- Supervising and guiding the Women and Children Protection Committees in their ward.
- Disseminating and coordination of information between the Council Women and Children Protection Committeesand the Mtaa/Village Women and Children Protection Committees.
- To monitor and evaluate implementation of NPA – VAWC at ward levels.
- To identify and compile list of CSOs/CBOs, FBOs and other key stakeholders supporting VAWC interventions.
- To develop and implement VAWC interventions in villages.
- To ensure VAWC interventions are integrated into village/mtaa development plans.
- To raise the profile of VAWC within the ward and village leadership and other key stakeholders through advocacy and regular reporting.
- To facilitate effective collaboration between all partners responsible for VAWC in the ward

- To mobilize resources to support VAWC activities.
- To report on NPA - VAWC progress to District Executive Director in a timely manner.
- Provide joint supervision on VAWC at ward level.
- Conducting ward level awareness-raising and advocacy concerning child rights, stigma reduction, and resource mobilization.
- Providing a link to other key committees and institutions such as the Ward Multi-Sectoral AIDS committee (WMAC), Ward Development Committee (WDC) and WVAWC Protection Committee/ Most Vulnerable Children Committee.

Child and Gender Police Desk

This is the unit within the Police Force that addresses violence against women and children and particularly sexual offences and domestic violence. Police officers have a special mandate in child protection. This is clearly stipulated under the Law of the Child Act No. 21 of 2009, Section 94, Sub Sections 6 and 7. This unit exists in all police stations and is staffed by officers who are specifically trained to deal with cases of child protection. The child and gender police desk is responsible for:

- Receiving complaints from the community, children themselves, parents/guardians and any other institution regarding any child abuse case/violence.
- Investigating all allegations of abuse or criminal violation of children's rights.
- Arresting offenders where there is adequate evidence that a child has been harmed or seriously threatened.
- Documenting and compiling information and making necessary referrals.
- Assisting victims with accessing medical examination and treatment.
- Protecting the child or other witnesses against manipulation or pressure to alter their statements or accusations.
- Protecting the victim or other witnesses from those who may intend to destroy the evidence take revenge.
- Communicating with Council Social Welfare Officer to ensure the child has maximum welfare and protection support.
- Removing the child to a place of safety if deemed necessary.

III. Council Level

Council Executive Officer

The Council Executive Officer oversees implementation of all activities on the district level and channels the information to the Regional Administrative Secretary.

Council Social Welfare Officer

In the case management system, the Council Social Welfare Officer has the statutory responsibility for the protection and safeguarding of children. ***This is clearly stipulated by the Law of the Child Act No.21 of 2009 Part III, Section 20, Sub Section A- D on duties of a Social Welfare on Care and Protection of a Child***. This is done through the provision of a wide range of services for children, adults and families.

The roles of the Social Welfare Officer within the NICMS include, but are not limited to:

- Serving as the government arm with the overall statutory mandate for child welfare and safeguarding.
- Conducting social investigation and intervening in cases of alleged abuse.
- Referring protection cases back to CCWs care in the community as needed and as deemed appropriate during or after protection issues are addressed.
- Providing direct services to children and families in complex or high-risk cases that cannot be adequately handled at community level.
- Coordinating all case management processes and actors at all levels.
- Providing oversight, guidance and review of case management practices: cases, care plans, referrals, case reviews.
- Providing technical backstopping for all case management actors.
- Ensuring that caseworkers maintain the necessary support for children and families throughout the duration of the case.
- Collecting case management data/information, analyse and share and disseminate to different stakeholders.
- Advocating for case management interventions and resource mobilizations from the Government, IPs and Private Sector.

Council Women and Children Protection Committees

The MoHCDGEC works in partnership with all government ministries, departments and agencies, and implementing partners that are involved in child protection and welfare interventions. Representatives of some of these agencies are required to be part of the District Child Protection team. These are multi-sectoral and multi-stakeholder structures put in place at national and LGA levels to coordinate implementation of child protection and safeguard interventions by various players at each level. Their roles and responsibilities include:

- Ensuring all District Council Departments plan and budget for the identified MVC.
- In collaboration with implementing partners, advocating for child welfare and protection amongst MVC stakeholders in the council.
- Ensuring capacity building for committees responsible for Most Vulnerable Children at ward level.
- Monitoring and evaluation of all MVC activities within the district including identification of implementation gaps (this will be done in collaboration with IPs).
- Building the capacity of Women and Children Protection Committee to advocate for care, support and protection from communities through children councils.
- Ensuring and overseeing the implementation of the developed MVC action plans.
- Conducting supportive supervision to Women and Children Protection Committee at ward and village/mtaa level.

The LCA Section 16, A to Q, states categories of children who are in need of care and protection. Any child who falls under these categories is identified as a Most Vulnerable Child. Therefore, it is important to have this structure at the council level which will be coordinating welfare and protection issues for MVC.

The broader functions as per the LCA child protection regulations 2015 are:

- Monitoring case management at district level.
- Coordinating responses to child protection concerns at district level.

- Meeting on quarterly basis and regularly to holding case conferences in child protection.
- Following up on the cases on a regular basis in their areas of jurisdiction.

IV. Regional Level

Regional Administrative Secretary (RAS) receives reports from all sections in the region and channels them to the President's Office and oversees implementation of all activities in the region.

Regional Social Welfare Officer (RSWO) advises, coordinates and conducts monitoring and supportive supervision, as well as facilitates social welfare issues at the regional level. In instances of case management their roles include, but are not limited to coordinating cases and the data base of all councils in the region.

PO-RALG is responsible for coordinating and overseeing the implementation of laws, policies, guidelines, and national plans of action pertaining to social welfare services at the regional and council level while also providing supportive supervision.

Local Government Authority Level Committee

The coordination of NPA – VAWC at local levels is key factor for effective implementation of NPA – VAWC. The PO – RALG will be responsible for coordination of all issues related to NPA – VAWC at regional, council, ward and village/mtaa level.

PO-RALG will perform the following roles:

- Strengthen the reporting and communication mechanism at local level.
- Submit consolidated reports of LGAs on NPA VAWC implementation to the National Steering Protection Committee (NSPC) and National Technical Protection Committee (NTPC).
- Ensure all implementing partners at LGAs are integrating VAWC interventions into their plans and budget.
- Liaise with development partners on resources mobilization and utilization.
- Convene stakeholders' council forum biannually to provide feedback on NPA – VAWC implementation.
- Conduct joint monitoring and evaluation visits at LGAs Level.
- Attend NPA-VAWC annual consultative meetings.

V. National level

The MoHCDGEC is responsible for making and disseminating laws, policies, guidelines, and national plans of action pertaining to social welfare services, and providing technical oversight.

National Committees

National Women and Children Protection Steering Committee (NWCPSC)

At national level, the **NWCPSC** will provide overall policy guidance and coordination of the NPA – VAWC and other welfare concerns. There is also the National Women and Children Protection Technical Committee (NWCPTC), Thematic Working Groups (TWGs) and NPA – VAWC Secretariat.

Each level has its roles and functions within the structure. The broader functions are:

- Identifying and providing child welfare and protection concerns at all levels.
- Coordinating responses and monitoring child welfare and protection concerns.
- Lobbying and advocating with local government authorities, institutions, the private sector and development partners (DPs) to prioritize commitment of resources to child welfare and protection activities and ensure close collaboration among stakeholders.
- Meeting regularly to discuss child welfare and protection issues.
- Developing, reviewing, disseminating and monitoring implementation of policies, guidelines, strategies, regulations and laws.

PART VI: QUALIFICATIONS, STANDARD TRAINING REQUIREMENTS

The frontline workers of the NICMS are trained community volunteers who work on a voluntary basis and who are formally linked with professional cadres such Social Welfare Assistants and Social Welfare Officers. In order to do their jobs effectively, CCWs must be provided with adequate training and technical support. The table below describes the training and qualifications required of the various social work actors in the NICMS:

Volunteer Categories	Required Qualifications (pre-service)	Training (induction or in-service)	Responsible Group
Community Case Workers	Basic literacy and numeracy; Must be a resident of that particular community; Must be vetted by local authorities	5-day CCW Training Additional mini-modules delivered by SWO/SWA through supportive supervision	MoHCDGEC/PO-RALG
Para-Social Workers (Lead Community Case Workers)	Form 4 Leaving Certificate; Must be a resident of the community; Must be vetted by local authorities	10-Day LCCW Training	ISW
Para-Social Worker/ LCCW Supervisors	See: Social Welfare Officer, Social Welfare Assistant	10-day LCCW training; (ISW) 4-day LCCW supervision training (ISW); 5-day CCW case management training	MoHCDGEC/PO-RALG
Social Welfare Assistants	Social Welfare Assistant Certificate from ISW	One year training on social work	ISW
Social Welfare Officers	Diploma or University Degree	10-day child protection training: 5 on general child protection and 5 days on the Law of the Child Act and Regulations.	MoHCDGEC/PO-RALG

The training modules listed above are national training materials that cover the core competencies needed to manage Most Vulnerable Children cases at each level.

The case management training received by all volunteers and supervisors provides basic coverage of concepts needed for assessing and working with MVC, with specific attention to HIV-sensitive case management. Included in the training are the structures, functions, and requirements of the NICMS, as well as material on child development, the effects of neglect and abuse, HIV, and basic child and family assessment and counselling skills. It also includes, ongoing education to promote skills development provided through follow-up trainings and technical support.

PART VII: SUPPORTIVE SUPERVISION

Supportive supervision in the NICMS is designed to ensure quality service delivery through providing a formal system of support from the national level down to the community case worker, through monitoring performance and ensuring adherence to set care standards. The broad functions of supervision are the following;

- To promote provision of quality of care.
- To enhance the development of knowledge and skills on case management.
- To provide a platform for sharing of CCWs' experiences and concerns.
- To assess and improve community case worker performance.

I. Village/Mtaa Level

The LCCWs provide supportive supervision to CCWs on the monthly basis. The monthly village/mtaa level supportive supervision meetings will include discussion of systems challenges in the provision of care within the NICMS as well as discussion of outstanding complex cases. Furthermore, joint supportive supervision at the village/mtaa level will be conducted by the members of the Women and Children Protection Committee on monthly basis.

II. Ward Level

On a monthly basis, WSWO/SWA provides supportive supervision to the LCCWs and CCWs. The monthly ward level supportive supervision meetings will include discussion of systems challenges in the provision of care within the NICMS as well as discussion of outstanding complex cases that are posing management challenges. Furthermore, joint supportive supervision at the village/mtaa level will be conducted by the members of the ward Women and Children Protection Committee on quarterly basis.

III. Council Level

On a quarterly basis, CSWOs provide supportive supervision to the WSWO, SWA, or any other assigned officer functioning in a supervisory role with ward level supervisors of LCCWs and CCWs. The monthly council level supportive supervision meetings will include discussion of systems challenges in the provision of care within the NICMS as well as discussion of outstanding complex cases that are posing management challenges. Furthermore, joint supportive supervision at the ward level will be conducted by the members of the council Women and Children Protection Committee on quarterly basis.

IV. National Level

At the national level, a selected cadre of representatives from PO-RALG, MoHCDGEC, and implementing partners will undertake joint supportive supervision at RA and LGA on a quarterly basis.

ANNEXES

Annex 1: NICMS Most Vulnerable Children and Household Registration Form

Form No 1: Most Vulnerable Children and Household Registration Form

Region:_____ Council:_____ Ward:_____ Village/Mtaa:_____

Name of Caseworker/Volunteer:_____ Mobile phone No.:_____ Institution:_____ Date of registration:_____/_____/_____ (dd) (mm) (yyyy)

A. Household Information

SN	[A] Primary caregiver unique ID No.	[B] Name of primary caregiver (First, middle & surname)	[C] Sex (M/F)	[D] Year of birth	[E] Age (yrs)	[F] Type of MVC household	[G] Primary caregiver employment status	[H] Household has a health insurance card	[I] Primary Caregiver vulnerability
						1. Child headed 2. Adult headed 3. Elderly headed	1. Employed 2. Unemployed 3. Self employed	1. YES 2. No	1. Disabled 2. Confirmed HIV 3. Chronically ill 4. Others
						1 2 3	1 2 3	1 2	1 2 3 4
1									

B. Child Information

SN	[J] Child unique ID No.	[K] Name of child (First, middle & surname)	[L] Sex (M/F)	[M] Date of birth (dd/mm/yy)	[N] Age (yrs)	[O] Birth certificate No.	[P] MVC vulnerability	[Q] # disabled, type of disability	[R] Child in school	[S] Level of school (check only one option)	[T] Standard/ Form (write in one option)	[U] Child primary caregiver	[V] Case opened
							1. Orphaned 2. Confirmed due to HIV 3. Confirmed due to other causes 4. Living with HIV 5. Malnourished 6. Out of school 7. Living/working on the street 8. Child living in institutional care 9. Child with disability 10. Child at risk or suffering from violence, abuse and neglect 11. Others	1. Albinism 2. Physical 3. Hearing 4. Visual 5. Physical 6. Speech impairment 7. Multiple 8. Others	1. Yes 2. No	1. Early childhood development 2. Pre-primary 3. Primary 4. Secondary 5. Vocational training 6. College	1. If Primary school, enter level/Std. 2. If Sec. school, enter level/Form.	1. Father/Mother 2. Brother/Sister 3. Aunt/Uncle 4. Stepfather/mother 5. Grandfather 6. Institutional care 7. Cousin 8. Family friend 9. Foster parent 10. Adoptive parent 11. Other	1. Yes 2. No
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													

Remarks:_____

Approved by:_____ Position:_____ Signature:_____ Date:_____

Annex 2: NICMS Intake Form for Social Welfare Officers

Government of Tanzania, Department of Social Welfare — Child Protection Case Management System (Form 1)

Initial Referral

Name of Child: _____ Case Number: _____

Sex: _____ Date of Birth (Age): _____

Address / Contact Details of Child/Family: _____

_____

1. Source of Referral (Details of person making the Referral to the SWO)

Name: _____ Relationship to the Child: _____

Contact Details: _____

_____

Method of Referral: _____ Date of Referral: _____

If the referral is made by a Professional how did they become aware of the case? _____

_____

2. Reason for Referral

Briefly outline the reasons(s) for/circumstances of the referral (continue overleaf if necessary). Enter any other factual details, including contact information, biographical details of the child, etc.) should be entered into the "Case Details" Form.

_____

_____

_____

_____

_____

_____

_____

_____

_____

3. Prior History of Child Protection Concerns - give details of any previous DSWO involvement with the child, their family and/or the alleged perpetrator (enter an "X" in the relevant box(es))

Child: ☐ Family: ☐ Alleged Perpetrator: ☐

Reference Number of Child's Reopened File(s): _____

Give Brief Details: _____

4. Assessment of Intake SWO

Briefly describe your assessment of the hazard to which the child is exposed, the likelihood of harm to the child, its potential seriousness and the ability of any carer(s) to protect the child. On this basis select the option that best describes your assessment of the risk and the action required in section 5 below (continue overleaf if required).

5. Cause for Concern

Record your decision as to whether the child is a "Cause for Concern" and what further action is required (enter an "X" in the relevant box))

Yes - **There is a Cause for Concern** (the child is at risk of significant harm). An Initial Investigation should take place at the earliest opportunity.

No - **There is NO Cause for Concern** (the child is not at significant risk of harm). The child's file can be closed. If the child requires any other (non-Child Protection) support, the case should be referred to another suitable service provider.

6. Emergency Actions

Give details of any emergency actions taken prior to completing the Initial Investigation (only applicable for cases where the Child is assessed to be a "Cause for Concern")

Completed by:

Name	Signature	Date

7. District Social Welfare Officer's Comments

Name	Signature	Date

Follow-up Actions:

Date Referral Acknowledged:

Date Referrer notified of Decision:

Child Assessment and Care Plan

Directions: Use the Child Assessment Job Aid to gather information to develop this care plan. This care plan should be developed jointly by the CCW, caregiver, and child. There is space on this plan to update the care plan during the year, once every three months. If the child is still requiring services after one year, a new care plan form should be used.		
Child's full name:	**Name and title of CCW completing care plan:**	**Name of caregiver involved in care plan development:**
Child's date of birth: **Child's sex:**		
Child's assigned unique ID (if applicable):	Signature:	Signature:
Child's signature indicating that he/she was involved in care plan development (only for relevant ages):		
Describe the strengths of the child's household:		
Describe the primary challenges of the child's household:		
Describe the basic goals of this care plan:		

Child Assessment and Care Plan

Domain	Initial visit #1 Date of Visit:			Quarterly follow up #2 Date of Visit:		Quarterly follow up #3 Date of Visit:		Quarterly follow up #4 Date of Visit:	
	Based on the Child Assessment job aid, what is the child's situation in each domain?	Plan for services/referrals including actions and persons/ organizations responsible	Dates actions to be completed	Plan for services/referrals including actions and persons/ organizations responsible	Dates actions to be completed	Plan for services/referrals including actions and persons/ organizations responsible	Dates actions to be completed	Plan for services/referrals including actions and persons/ organizations responsible	Dates actions to be completed
Health and Nutrition									
Shelter and Care									
Protection									
Psycho-social									
Education and Skills Training									
Other									

Annex 4: NICMS Assessment Form for Social Welfare Officers

Government of Tanzania, Department of Social Welfare **Child Protection Case Management System (Form 8)**

Review of Care Plan

Use this form to summarise the outcome of any formal review of the Care Plan. Record any achievements, challenges or changes relating to the individual activities on the Planning Matrix.

Number of Review:

Name of the Child: _____ **Case Number:**

1. Review of Progress

Summarise that has happened since the Plan was drafted or the most recent review, highlighting key achievements and challenges, giving reasons where relevant.

2. Views of the Parent(s), Guardian(s) or Carer(s) and of the Child

What are the views of the child's Parent(s), Guardian(s) or Carer(s)?

What are the wishes and feelings of the Child?

Form 8, Page 1

3. Outcome of the Review / Proposed Changes

Summarise any changes made to the Plan and what support will be provided to achieve them and to overcome any challenges faced during the previous period.

4. Consent/Acknowledgement

The parent(s), guardian(s) or carer(s) and the child should indicate their agreement to the revised Plan by signing below (if it is not possible or appropriate to get agreement, explain why).

Signature of Parent(s), Guardian(s) or Carer(s) | **Signature of the Child**

5. Roles and Responsibilities of Key Professionals

	Name	Position	Responsibility	Contact Details
1)				
2)				
3)				
4)				

6. Signature of the SWO responsible for the case

Name(s) | **Signature(s)** | **Date**

7. District Social Welfare Officer's Comments

DSWO:

Name | **Signature** | **Date**

Annex 5: Referral Form for Community Case Workers

Instructions: This form should be completed by service providers when Referring MVC. Referring Provider should fill all parts A and B. Part C should be filled by service provider receiving the referral

Form No 6: MVC Referral

SECTION A: INITIAL DETAILS

Name of person referring:_____ **Position**_____ **Institution:**_____ **Signature:** _____ **Mobile No.** _____

Council:_____ **Ward**:_____ **Village/Mtaa:**_____

Name of a child/caregiver:_____ **Sex**_____ **Age**_____ **Unique ID No :** _____ **Mobile No:**_____ **Date referral made (dd/mm/yy**

Service provided before referral:_____

Referred to (name of organization) :_____ **Physical adress of the referral site :** _____

SECTION B: LIST OF SERVICES AND SERVICES PROVISION SITES

List of Services	Service Provision Site
Health	
HIV related services	
☐ 101. HIV counselling and testing	☐ 101. Health facility
☐ 102. HIV care and treatment	☐ 102. VCT centers
☐ 103. ART adherence education	☐ 103. Drop - in centers
☐ 104. HIV prevention education	☐ 104. CTC centers
☐ 105. HIV disclosure support	
☐ 106. TB/HIV screening	☐ 105. RCH clinics
☐ 107. PMTCT services	☐ 106. Maternity homes/Labour and delivery centers
☐ 108. STI treatment services	☐ 107. Immunization sites
☐ 109. Opportunistic infections treatment (OIs)	☐ 108. Youth groups/ teen clubs/children clubs
☐ 110. Home Based Care Services (HBC)	☐ 109. Community health workers, CBOs/FBOs and Community Case Worker
☐ 111. Post Exposure Prophylaxis (PEP)	☐ 110. ECD Centers
RCH Services	
☐ 112. Antenatal care services (ANC)	
☐ 113. Labour and delivery	
☐ 114. Postnatal services	
☐ 115. Family Planning (FP)	
☐ 116. Immunization	
☐ 117. Integrated management of childhood illness (IMCI)	
☐ 118. Early Childhood development /Care for Child Development	
☐ 119. Deworming	
Other health services	
☐ 120. Malaria prevention	
☐ 121. Diarrhoea treatment	
☐ 122. Mental Health services	
☐ 123. Non Communicable Diseases (NDC)	
Nutrition	**Nutrition**
☐ 201. Nutrition status assessment, counselling and support	☐ 201. Districts nutrition officer
☐ 202. General food support	☐ 202. CSOs, FBOs and CBOs
☐ 203. Supplemental feeding services	☐ 203. Agricultural extension officer
☐ 204. Therapeutic feeding services	☐ 204. Health facility
	☐ 205. Village and ward executive office
	☐ 206. Health officer
Education	**Education**
☐ 301. Early Childhood development	☐ 301. ECD Centers
☐ 302. Education subsidies for children	☐ 302. School
☐ 303. Life skills education	☐ 303. Vocational training centers
	☐ 304. Youth Groups/Teen clubs/Children clubs
	☐ 305. Peer education groups
Child Protection	**Child Protection**
☐ 401. Birth registration /Certificate	☐ 401. Legal Aid Center/Provider
☐ 402. Support for street children	☐ 402. School
☐ 403. Support for exploited children	☐ 403. DAS/District council
☐ 404. Legal Aid and other support	☐ 404. Health facility/BOH
☐ 405. Child protection case investigation and Response services	☐ 405. Police station/Gender and children desk
☐ 406. Parenting education	☐ 406. Village/WEO office
☐ 407. General child protection education	☐ 407. CSOs/FBOs
☐ 408. Temporary Shelter	☐ 408. Fit person/foster parent
☐ 409. Emergency Care and Support	☐ 409. District social welfare
☐ 410.CCD	☐ 410. Institutional care
	☐ 411. Community development officer
	☐ 412. Parenting groups
	☐ 413. MVCC/Child protection team
	☐ 414. Vocational Training/College
	☐ 415. Income Generating Group
	☐ 416.CCD home visit
Psychosocial care and support	**Psychosocial care and support**
☐ 501.Counselling	☐ 501. Social welfare office
☐ 502. Social participation	☐ 502. Counelling centre
☐ 503. Child welfare education	☐ 503. Health center
☐ 504. Cultural and Spiritual support services	☐ 504. Children clubs/Peer groups
☐ 505. Alcohol and Drug Abuse Support	☐ 505. School
	☐ 506. Religious institutions
Economic Strengthening	**Economic Strengthening**
☐ 601. Cash Transfers (TASAF)/Saving and Lending Support	☐ 601. TASAF/CBO/FBO/NGO/Private For Profit companies
☐ 602. IGA, small business/entreprise support	☐ 602. Saving and lending groups
☐ 603. Vocation skills support	☐ 603. VETA/FDC/VTC
☐ 604. Agricultural and extension service support	☐ 604. Extension officer E.g Agricultural officer
☐ 700. Others, please specify _____	☐ 700. Others, specify _____

SECTION C: FEEDBACK ON SERVICE PROVIDED (This section to be filled by service provider who received the referral; and the slip to be returned to the referring provider)

Date of referral service provided (dd/mm/yyyy):_____ **Name of a person referred:**_____

Service Provided:_____ **Service completed as required:** Yes ☐ No ☐

Follow- up needed: Yes ☐ No ☐ **Follow up date(dd/mm/yyyy):**_____

Name of the referral site: **Name of the receiving provider :**

Designation: **Mobile No:** **Signature:**

Remarks:

Annex 6: NICMS Care Plan for Social Welfare Officers and Assistants

Government of Tanzania, Department of Social Welfare **Child Protection Case Management System (Form 7)**

Care Plan

Use this form to record the details of any Care Plan that is prepared for the child, whether they are in Voluntary Care or subject to a Care or Supervision Order. Use this form in combination with the Planning Matrix to record the all individual activities or actions required to meet the needs of the child, including the support that will provided by professionals and what is expected of the child and their carer(s).

Name of the Child: _____ **Case Number:** _____

1. Care Arrangements

Record the type of placement and the type of care involved (i.e. remaining in the care of their parents/guardians or placed in Kinship Care, with a Foster Carer/Fit person or in a Children's Home (use an "X" to indicate the selected options)

a) Type of Placement

Voluntary (with consent of the parent(s)) ☐ Care or Supervision Order ☐

b) Type of Care

Child remaining in the care of parent(s) or guardian ☐ Placement in Kinship Care ☐

Placement with a Fit Person/Foster Carer ☐ Placement in a Children's Home ☐

c) Details of the Child's Care Giver during the period of the Plan (e.g. Parent(s), Guardian(s), Relative, Foster Carer or Children's Home Manager, etc.)

Name(s): _____

Address/Contact Details: _____

2. Summary of the Child's Needs and the Risks to which he/she is exposed

_____

_____

_____

_____

_____

3. Views of the Parent(s), Guardian(s) or Carer(s) and of the Child

What are the views of the child's Parent(s), Guardian(s) or Carer(s)?

_____

_____

_____

_____

What are the wishes and feelings of the Child?

_____

_____

_____

_____

4. Access Arrangements

What arrangements have been made for access between the child and their parent(s), guardian(s) or carer(s) and other important individuals in their life?

5. Longer Term Plans for the Care of the Child

What are the long term plans for the upbringing of the child? If the child is in temporary alternative care, what are the plans for reunification with his/her birth parents (if any) and if this is not possible what other long term alternatives are being considered (e.g. Adoption)?

6. Monitoring and Review of the Plan

What are the arrangements for monitoring the Plan? (Who is responsible and how often will they meet with the Child?)

When will the 1st review of the Plan take place?

7. Consent/Acknowledgement

The parent(s), guardian(s) or carer(s) and the child should indicate their agreement to the Plan below (if it is not possible or appropriate to get agreement, explain why).

Signature of Parent(s), Guardian(s) or Carer(s) | **Signature of the Child**

8. Roles and Responsibilities of Key Professionals

	Name	Position	Responsibility	Contact Details
1]				
2]				
3]				
4]				

9. Signature of the Social Welfare Officer responsible for the case

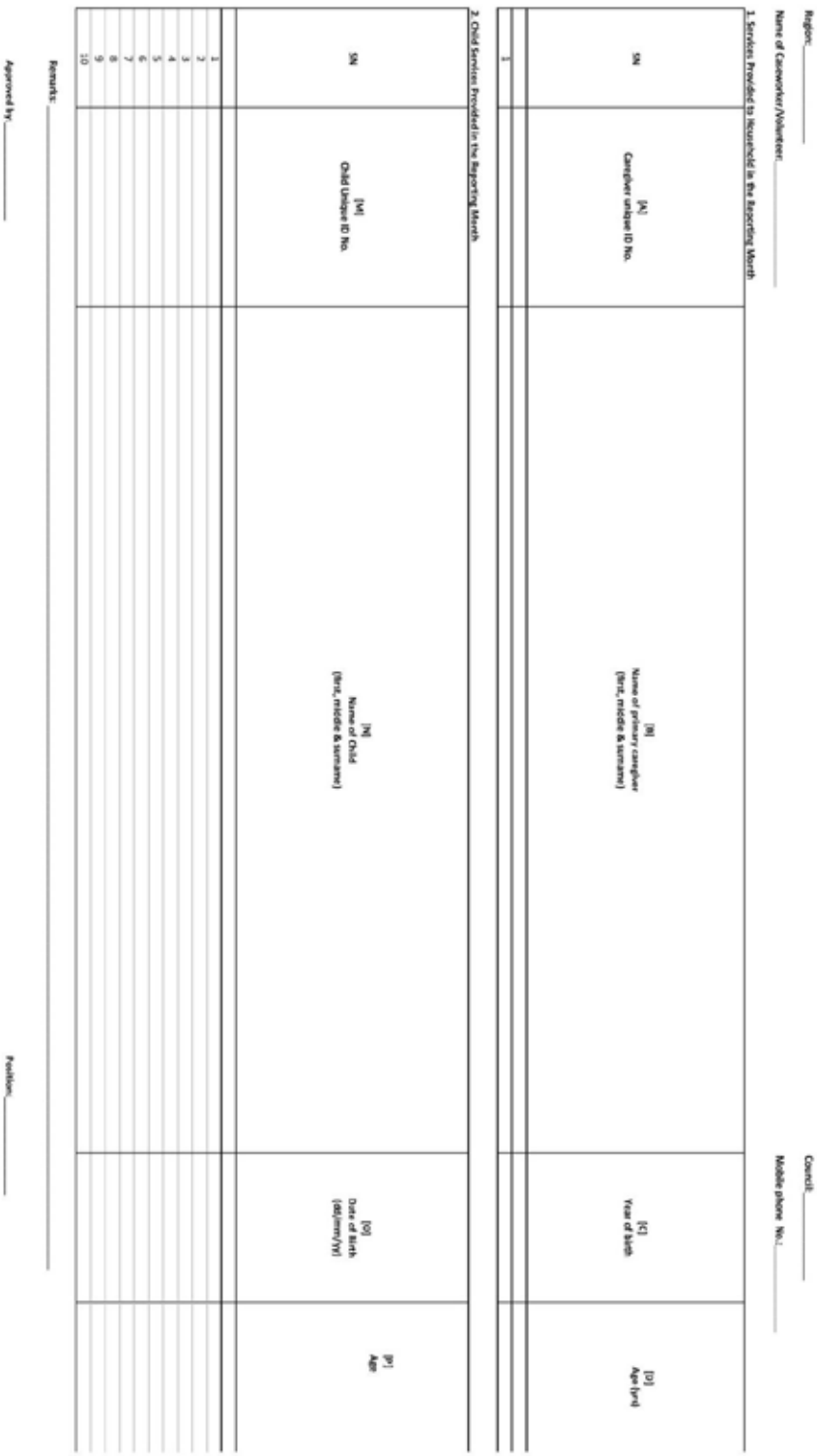
Name(s) | **Signature(s)** | **Date**

10. District Social Welfare Officer's Comments

DSWO:

Name | Signature | Date

Annex 7: NICMS Monthly Service Tracking Form for Community Case Workers



Region:_____ Council:_____

Name of Caseworker/Volunteer:_____ Mobile phone No.:_____

1. Services Provided to Household in the Reporting Month

SN	[A] Caregiver unique ID No.	[B] Name of primary caregiver (first, middle & surname)	[C] Year of birth	[D] Age (yrs)
1				

2. Child Services Provided in the Reporting Month

SN	[M] Child Unique ID No.	[N] Name of Child (first, middle & surname)	[O] Date of Birth (dd/mm/yy)	[P] Age
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Remarks:_____

Approved by:_____ Position:_____

Instructions: This form should be completed by caseworker/volunteer on a monthly basi
7th of every month and one copy to district social welfare officer by 10th of every month
is to be used for reporting narratives- challenges, constraints and recommendations.

Form No. 2: Most Vulnerable Children Monthly Service Tracking Form

	Date of v
Visits	Visit 1
Date of visit	

Ward:_____ Village/Mtaa:_____

Institution_____ Reporting Month/Year:_____/_____
(mm) (yyyy)

	[F] Parenting (for caregivers with children of <5 years old)					[G] Nutritional status assessment (MUAC)			[H] Food and nutrition			[I] Health care							[J] Household economic strengthening							
[E] Sex (M/F)	1. Received Care for Child Development (CCD) education during a CHW home visit 2. Received ECD education at children's corners in HF 3. Caregiver linked to community parenting groups 4. Received parenting messages 5. Received infant and young child feeding counseling					1. Severe malnutrition 2. Moderate malnutrition 3.Not malnourished			1. Caregiver received nutrition counseling 2. Household linked to external food support & nutritional supplements 3. Other services			1. Received HIV risk assessment 2. Received HIV prevention counseling services 3. Received disclosure support 4. Linked to an HIV support group 5. Received ART adherence counseling 6. Supported to join CHF/TIKA 7. Caregiver received support for GBV							1. Primary caregiver is an active SLG member 2. Household linked to temporary consumption support (e.g. SLG & OVC funds) 3. Household linked to cash transfer eg TASAF 4. Linked to entrepreneurship trainings 5. Primary caregiver supported to establish income generating activity (IGA) 6. Household linked to market 7. Household supported to prepare succession plan 8. Primary caregiver linked to agricultural extension support							
	1	2	3	4	5	1	2	3	1	2	3	1	2	3	4	5	6	7	1	2	3	4	5	6	7	8

	[R] Education and vocational training						[S] ECD & psychosocial support			[T] MVC<5 years		[U] Nutritional Status Assessment			[V] Health care							[W] Child protection				
[Q] Sex (M/F)	1. Child is enrolled in school 2.Child missed school for three or more days consecutively in a month 3. Child linked to education support 4. Child supported to attend vocational training 5. Child received business start-up kit 6. Child linked to mainstreamed education program (MEMKWA)						1. Child (<5 years) attended ECD centre 2. Child attended children's clubs 3. Child attended teen clubs			1.Yes 2. No		1. Severe malnutrition 2. Moderate malnutrition 3. Not malnourished			1. Child supported to join CHF/TIKA 2. Child received HIV prevention counselling services 3. Child received disclosure support 4. Child linked to HIV support group 5. Child received ART adherence counseling 6. Child received HIV risk assessment 7. Child provided with HIV prevention education							1. Child supported to get birth certificate 2. Child provided with emergency care and support se 3. Child linked with social welfare office 4. Child linked with MVCC/Child protection team 5. Provided with general child protection awareness cr				
	1	2	3	4	5	6	1	2	3	1	2	1	2	3	1	2	3	4	5	6	7	1	2	3	4	5

Mobile No.:_____ Signature:_____ Date:_____

s. One copy of completed form should be submited to VEO on 5th of every month, one to WEO on
i. By 15th of every month, data should be entered into the DHIS2 by DSWO .The space for remarks

isits (dd mm yy)			
Visit 2	Visit 3		Visit 4

[K] Caregivers referrals												[L] Shelter & hygiene		
K1. Type of referral							K2.Types of referral		K3. Support provided to Caregiver Referrals					
1. Health -related services 2.Nutrition 3.Education 4. Child protection 5. Psycho social support 6. Economic strengthening 7. Others							Health -related servic 2. Nutrition 3. Education 4. Child protection 5. Psycho social supp 6. Economic strength 7. Others		1. Number of caregivers referrals accompanied to a service(s) 2. Number of caregivers referrals assisted with			1. Household linked to house renovation support 2. Household linked to house construction support 3. Received water, sanitation and hygiene (WASH) education 4. Household receveid clothing support		
1	2	3	4	5	6	7	1	2	1	2		1	2	3

	[X] Child referrals											[Y] Status in program				
	X1:Type of referral							Types of referral		X3: Support		1. Active 2. Graduated 3. Transferred 4. Exited without graduation 5. Died				
rvices eation	1. Health -related services 2.Nutrition 3.Education 4. Child protection 5. Psycho social support 6. Economic strengthening 7. Others							1. Health-related 2. Nutrition 3. Education 4. Child protection 5. Psycho social 6. Economic 7. Others		1. Accompanid to a s 2. Asisted with transp						
)	1	2	3	4	5	6	7	1	2	1	2	1	2	3	5	5

Annex 8: NICMS Case Closure Form

CASE CLOSURE FORM

Name of Child: ..... **Sex of Child:** .....**Child's D.O.B**.....

Child's assigned unique ID number: .....

Date Case Opened: ....**Date Case Closed:**..... **# of Months Case Open:** .....

Services Provided:	**Tick**	**No. of Sessions/ calls/ visits/ referral organization names/ etc.**
Counselling provided to child's caregiver		
Counselling provided to child		
Follow-up phone calls made		
Follow-up home visits conducted		
Seen child		
Spoken with child directly		
Referrals made (name service providers)		
Other (*Please explain*)		

Assessment of Current Status of Child's safety & well-being:_____
_____
_____

Comment on Outstanding Needs of Child (if any) & future care plan:_____
_____
_____

Reasons for Case Closure (tick one):

- ❑ Graduation/care plan achievement
- ❑ Case transferred to another locality or service provider for case management services

Exit without graduation:

- ❑ Caregiver/child requested to terminate services
- ❑ Relocated/moved away
- ❑ Cannot be located
- ❑ Died
- ❑ Other, specify:_____

Date of Notification of Case Closure to Child: _____ **Caregiver:** _____

Child aware of how to re-access services in future? ❑ **Yes** or ❑**No**

Type of information (e.g. Flyer/Sticker/ Pamphlet/ Poster/Name of service provider) given to child to access child protection services in future: _____
_____
_____

Case Worker Name & Signature:_____ **Date:**_____

Case Manager Name & Signature:_____ **Date:**_____

Annex 9: Monthly Summary Report Form for Community Case Workers

Form No. 3: Most Vulnerable Children Monthly Summary Report Form

Region:_____ Council: _____ Ward: _____ Village/Mtaa: _____

Name of Caseworker/Volunteer:_____ Mobile phone No. _____ Institution: _____ Reporting month: / _____

Page 1: Household and Child Registration Summary

Table A: Household Registration Information

[F]	[G]	[H]	[I]	[I]	[I]
	1. Number of Employed 2. Number of Unemployed 3. Number of Self Employed	1. Number of households with health ris 2. Number of households with no health	1. Number of disabled caregivers 2. Number of caregivers living with HIV 3. Number of chronically ill caregivers		1. Number of disabled caregivers 2. Number of caregivers living with HIV 3. Number of chronically ill caregivers

Age & sex category	1		2		3		1		2		3		1		2		3	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
17 & <																		
18-24																		
25-59																		
60+																		
Total																		

TABLE B: Child Registration Information

	[O]		[P]		[Q]
			1. Number of disabled MVC 2. Number of MVC orphaned due to HIV 3. Number of orphaned due to other causes 4. Number of MVC living with HIV 5. Number of malnourished MVC 6. Number of children in conflict with law 7. Number of MVC Living/working on the street 8. Number of children living in institutional care 9. Number of MVC in worst form of child labor 10. Number of children at risk or suffering from violence, abuse and neglect 11. Others		1. Number of MVC v 2. Number of MVC v 3. Number of MVC v 4. Number of MVC v 5. Number of MVC v 6. Number of MVC v 7. Number of MVC v 8. Others

Age & Sex	M	F	1 M	1 F	2 M	2 F	3 M	3 F	4 M	4 F	5 M	5 F	6 M	6 F	7 M	7 F	8 M	8 F	9 M	9 F	10 M	10 F	11 M	11 F	1 M	1 F
<1																										
1-4																										
5-9																										
10-14																										
15-17																										
18+																										
Total																										

	[R] Child in school		[S] Level of school					
/ith albinism /ith mental disability /ith hearing disability /ith visual disability /ith physical disability /ith speech impairment /ith multiple disability	1. Number of children in school 2. Number of children not in school		1. Number of MVC in early childhood development level 2. Number of MVC in pre- primary school 3. Number of MVC in primary school 4. Number of MVC in secondary school 5. Number of MVC in vocational trainings 6. Number of MVC in colleges					
2	3	4	5	6	7	8	1	2	1	2	3	4	5	6
M F	M F	M F	M F	M F	M F	M F	M F	M F	M F	M F	M F	M F	M F	M F

[U] **Child primary caregiver**											[V] **Case opened**	
1. Number MVC under father/mother care 2. Number MVC under grandfather/mother care 3.Number MVC under aunt/uncle care 4. Number MVC under stepfather/mother care 5. Number MVC under sister/brother care 6. Number MVC under institutional care						7. Number MVC under cousin care 8. Number MVC under family friend care 9. Number MVC under foster parent care 10. Number MVC under adoptive parent care 11. Other					1.Number of cases opened	
1		2		3		4		5		6		7		8		9		10		11		1		2	
M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F

Annex 10: HIV Risk Services and Adherence Assessment Guide

Guide to Administer the HIV Risk, Services, and Adherence Assessment for Children and Adolescents (age 0-19)

Directions for PSWs/CCWs: This tool should be completed twice per year. Complete one tool per child/adolescent.

What: This document describes how to administer the "HIV Risk, Services, and Adherence Assessment" for children and adolescents (age 0-19) enrolled in the USAID Kizazi Kipya project.

Why: It is important that this tool is administered properly and consistently across project sites.

When: This guide is appropriate in 2017 and may be updated in 2018.

Who: This document is for Pact Staff, CSO staff, LGA representatives, Para-social workers (PSWs), and Community Case Workers (CCWs).

Key definitions:

- **Caregiver:** Refers to the parent who has the greatest responsibility for the daily care and rearing of a child.
- **Child:** A person below the age of 18
- **Adolescent girls and boys:** This is defined as individuals (boys and girls) who are age 10-19.

Guide for PSWs/CCWs to Administer the HIV Risk, Services, and Adherence Assessment:

This tool consists of 27 questions grouped into four parts.

- **Part A:** This part covers demographic information, and HIV status questions.
- **Part B**: This should only be completed for children/adolescents who are HIV negative or have an unknown HIV status. This part of the tool identifies children/adolescents who are at risk of HIV and should be referred to HIV testing and counseling.
- **Part C**: This should only be completed for children/adolescents who are HIV positive. This part identifies needed HIV services.
- **Part D**: This section tracks needed referrals for HIV services.

This tool will take approximately 30 minutes to complete.

Part A: HIV Status – fill for all children and adolescents

Questions		Guide/instructions
Unique ID of Caregiver		Insert unique identification number assigned to the child/adolescent. Each child/adolescent has his/her own unique identification number. The unique ID has eight-digits in this format: **Region/District/Category/12345678**
Child/adolescent's full name		Insert the full name of the child/adolescent. The name includes all three names: first name, middle name, and surname.
Child/adolescent's age		Insert age of the child/adolescent in years.
Child/adolescent's sex		Tick the appropriate sex of the child/adolescent.
Date of the case review		Insert the date when the HIV Risk, Services, and Adherence Assessment was administered. The format is day, month, then year. If the date is between 1-9 then place zero first. For example, if the tool was administered on January 5 2017, then write date as 05-01-2017
Name of the PSW/CCW		Insert full name of the PSW/CCW completing the tool. The full name should include first name, middle name, and surname.
Risk factors		
Item/Questions		**Description**
1	**Has the child ever tested?**	HIV status is defined as the state of either being infected with HIV or not. This question seeks to identify if the child has ever received HIV test. Review the case file, specifically the National MVC Registration form "column P"
2	**If the child has been tested what were the results?**	Prior to asking this question, tell the caregiver that this is a sensitive question. This question seeks to know the results of the HIV test conducted. HIV test results can be: 1. Positive: there is HIV virus 2. HIV negative: there is no HIV virus 3. Discordant result: the test conducted cannot tell whether there is HIV or not. This type of result requires a repeat test after 2-4 weeks. Review the case file, specifically the National MVC Registration form "column P"

Part B: HIV Testing – fill for OVC who are HIV negative, have not tested in the previous six months, or have an unknown status.

Section #1: For questions 3-10 review the child/adolescent's case file and use information to respond to the questions. If the information in the case file is not enough to fill in the required information, indicate "don't know."		
SN	**Item/Questions**	**Description**
3	**Is the child living in a child-headed household?**	A child is defined as a person under the age of 18 years. This question seeks to identify if the child is living in a household headed by a child (under 18 years old). Review the case file, specifically the Screening and Enrollment Form, question 13.
4	**Is the child living with a chronically ill/elderly caregiver who is unable to meet the child's basic needs?**	This question seeks to identify a child whose caregiver is chronically ill or old who is unable to meet the child's basic needs. Chronically ill caregiver: defined as a caregiver who has any disorder that persists over a long period (more than three months) and affects physical, emotional, intellectual, vocational, social, or spiritual functioning. This can also be defined as a caregiver who is unable to perform at least two activities of daily living such as eating, toileting, moving from place to place, bathing, and dressing. Elderly caregiver: defined as a caregiver age 60 or older. Child's basic needs include education, health care, food/nutrition, shelter, HIV/AIDS services, ECD services, emotional support, and physical protection.

		Review the case file, specifically the Screening and Enrollment Form question 13, to see if this child is living with a caregiver who is chronically ill or elderly who cannot meet the child's basic needs.
5	**Is the child living and/or working in the streets or in mining?**	This question seeks to identify a child who spends most or all her/his time in the streets. This question also seeks to identify children who are working in mining activities. Review the case file, specifically the Screening and Enrollment Form question 13, to see if this child is living and/or working in the street or mining.
6	**Is the child malnourished?**	This question seeks to identify malnourished children as measured by Middle Upper Arm Circumference (MUAC). Review the case file, specifically the Monthly Service Tracking Tool. Refer to column R: Nutrition status assessment (MUAC) to find the most recent nutritional status.
7	**Are one or both biological parents of the child deceased?**	This question seeks to identify if one or both biological parents are deceased/dead. Review the case file, specifically the Screening and Enrollment Form question 13, to see if one or both biological parents are dead.
8	**Are one or more household members' HIV positive (e.g. caregiver, sibling, etc.)?**	This question seeks to identify if there is any member in the household who is HIV positive. HIV positive: This is defined as having had a positive HIV test. Review the case file, specifically the Screening and Enrollment Form question 13, to see if there is any household member who is HIV positive.
9	**Has the child ever been or is currently being abused?**	This question seeks to identify whether the child has been or is currently abused. • Child abuse: encompasses any physical, emotional or sexual violence towards a child. • Physical abuse: Includes being slapped, burned, pushed, hit with a fist (punched), kicked, whipped, or threatened with a weapon such as a gun or knife. • Emotional abuse: Includes making the child feel worthless or unloved, inadequate or not valued, or causing the child to feel threatened or in danger. • Sexual abuse: Includes involving the child in any sexual activity with another person – even if the child "agreed." Review the case file, specifically the Screening and Enrollment Form question 13, to see if this child you are about to assess has been or is abused.
10	**Is the child's caregiver a sex worker or a drug user?**	This question seeks to identify a child whose caregiver is either a sex worker or a drug user. A drug user is defined as a person who uses unprescribed drugs, illicit drugs, or other non-medical drugs. A sex worker is defined as any female or male who receives money or goods in exchange for sexual services, either regularly or occasionally. Review the case file, specifically the Screening and Enrollment Form question 13, to see if the caregiver of the child assessed is either sex worker or drug user. **If all responses to questions 3-10 are "No" or "No/don't know" proceed to Section #2. If one or more question is ticked "Yes," skip Section #2 and Part C then go to Part D: Issue referral.**

Section #2: This section includes questions 11-20. Prior to administering this section, explain to the beneficiaries that sensitive questions may be asked, and if they are uncomfortable with any question, they may refuse to answer any questions.		
SN	**Item/Question**	**Description**
	Relevant to all children age 6 weeks to 1 and half years	
11	**If the child is six weeks or older, has he/she been exposed to HIV during pregnancy, birth, and/or breastfeeding?**	Ask this question to the caregiver. An HIV exposed child is defined as any child whose mother is HIV positive during pregnancy, birth, and/or breastfeeding. This question is only relevant for HIV exposed children six weeks or older.
	The first part of section #2 includes questions relevant to all children/adolescents age 0-19 girls and boys	
12	**Has the child ever been admitted to a hospital before?**	This question seeks to identify if the child has ever been admitted to the hospital during their lifetime. Ask the child or caregiver: "Has the child ever been admitted to hospital?" The PSW/CCW can further probe: "Has the child ever spent the night at the hospital due to illness?" Tick "Yes" or "No/I don't know" based on the caregiver/child/adolescent response.
13	**Does the child have recurring skin problems?**	This question seeks to identify if the child has had skin problems that come and go. Recurrent skin problems include: • Raised bumps that are red or white • Skin rash, which might be painful or itchy • Scaly or rough skin • Peeling skin • Skin ulcers • Open sores or lesions • Dry or cracked skin • Discolored patches of skin **Ask and observe** if there any signs and symptoms of skin problems. Tick "Yes" or "No/I don't know" based on the caregiver/child/adolescent responses and observation.
14	**Has the child had poor health in the last 3 months?**	This question seeks to identify children who have had poor health in the last 3 months prior to administering of this tool. Poor health is defined as any of the following conditions for more than seven days during the past three months: • Coughs and colds • Ear infections • Diarrhea • Vomiting • Fever • Skin rashes • Worm infestation • Tonsillitis • Chicken pox • Measles • Mumps PSW/CCW can probe by asking specifically about the condition above. Remind the beneficiary of the date three months ago to help them remember.

		Tick "Yes" or "No/I don't know" based on the caregiver/child/adolescent responses and observation.
15	**Has the child had a cough for one month or more?**	This question seeks to identify a child who has had cough for one month or more. The question seeks to identify if a child has had history of cough for one more tot or more in his/her life time. Tick "Yes" or "No/I don't know" based on the caregiver/child/adolescent responses.
16	**Has the child or anyone in the child's household ever been prescribed TB treatment?**	This question seeks to identify a child or any other member of the household who have ever been prescribe TB treatment. Ask the child/caregiver if he/she has been prescribed by the doctor TB treatment. Tick "Yes" or "No/I don't know" based on the caregiver's responses.
17	**Does the child (0-5 years) show signs of developmental milestone delays?**	This question seeks to identify a child age 0-5 years who has signs of developmental delays. Ask the caregiver if she/he has noticed any signs of delays that are age appropriate in the following areas: • Seeing • Neck control • Crawling • Standing • Walking • Running • Speaking • Weight gain • Identification of people and items Tick "Yes" or "No/I don't know" based on the caregiver's responses.
The second part of section #2 includes questions relevant for adolescent girls and boys age 10-19		
18	**Is the adolescent sexually active?**	This question seeks to identify adolescents (boys and girls aged 10-19) who have started sexual intercourse. Be very careful with this question to not offend the beneficiary. Assess the environment/level of privacy/appropriateness and if the adolescent will be able to answer that question. • Ask the adolescent if she/he has a girl/boyfriend • Ask if she/he has ever seen a condom • Ask is he/she has ever used a condom • If not, ask why has she/her never used a condom From the answers, draw a conclusion if the girl or a boy has ever had sexual intercourse. Tick "Yes" or "No/I don't know" based on the adolescent's responses.
19	**Does the adolescent have a child of his/her own?**	This question seeks to identify adolescents who are already mothers or fathers. Be very careful with this question to not offend the beneficiary. Assess the environment/level of privacy/appropriateness and if the adolescent will be able to answer that question. Ask the caregiver if the adolescent has a child of his/her own. Ask the adolescent if he/she has a child of his/her own. Tick "Yes" or "No/I don't know" based on the caregiver/adolescent's responses.

The third part of section #2 includes questions relevant for adolescent girls age 10-19		
20	**Is the adolescent girl pregnant?**	This question seeks to identify adolescent girls who are currently pregnant. This question **should not be asked** directly to the adolescent or caregiver. Observe the adolescent girl and indicate if she is currently pregnant. Tick "Yes" or "No/I don't know" based on observation.

If all responses to questions 11-20 are ticked "No" or "No/don't know/refuse," stop here and do NOT issue a referral for HTC. If one or more are ticked "Yes," go to Part D: Issue referral.

Part C: ART Status (fill for only HIV positive children and adolescents)

Section #3: Interview the caregiver and child/adolescent Explain to the beneficiaries that sensitive questions may be asked, and they can refuse to answer any questions.		
SN	**Item/Question**	**Description**
	ART initiation	
21	**Has the child been enrolled into care and treatment clinic?**	This question seeks to identify if the child has been receiving services at the care and treatment (CTC) clinic. Ask the caregiver if the child has been attending the CTC (ask for her/him to provide CTC-1 card for verification). Tick "Yes" or "No" based on the CTC-1 card and the caregiver's response.
22	**Has the child started ART?**	This question seeks to identify if the child has started and is on ART medication. Ask the caregiver if the child has started ARV drugs. Ask to see the CTC-1 card and see if the prescribed medication is written on card. Tick "Yes" or "No" based on the CTC-1 card and the caregiver's response.
	ART adherence and Disclosure	
23	**Has the child been adherent to ART for the <u>past one month</u>?**	Adherence to ART is defined as taking 95% or more of the prescribed medication in a stated period. This question seeks to assess adherence to ART during the past one month. Steps to administering this question: • Ask the caregiver how many times a day the child is supposed to take her/his ARV medication. • Then ask the caregiver how many times the child missed her/his ARV medication during the past 30 days. Use the answers provided to decide whether the child is adherent or not: <u>Adherent:</u> • ART prescribed once per day - Missed 0-1 doses • ART prescribed twice per day - Missed 0-3 doses <u>Not adherent:</u> • ART prescribed once per day - Missed 2 or more doses • ART prescribed twice per day - Missed 4 or more doses Tick "Yes" or "No" based on the caregiver's responses.
24	**Has the child attended all CTC appointments in the last six months?**	This question seeks to identify if the child has attended all CTC appointments within last six months.

		Ask to see the CTC-1 card and see if all appointments were attended within 3 days as scheduled. Ask the caregiver this question as well. Tick "Yes" or "No" based on the CTC-1 card and the caregiver's response.
25	**If the child is age 8 or above, has the caregiver disclosed the child's HIV status to the child**	This question seeks to identify if the HIV positive child knows her/his status. Ask the caregiver if the child has been fully told his/her HIV status. Tick "Yes" or "No" based on the caregiver's response.
	Viral suppression	
26	**Has the child's CD4 been tested within last six months?**	This question seeks to identify if the child has received a CD4 test within the previous six months. Ask the caregiver if the child has been tested for CD4. Ask to see the CTC-1 card and look for the CD4 column and the date CD4 was tested. Tick "Yes" or "No" based on the CTC-1 card and the caregiver's response.
27	**If the child has been on ART for six months or more, has the child's HIV viral load been tested within the previous twelve months?**	This question seeks to identify children who have been on ART medication for six months or more and have received a viral load test within the previous twelve months. Ask the caregiver if the child has received a viral load test within the previous twelve months. Ask to see the CTC-1 card and look for documentation if a viral load test was conducted. Tick "Yes" or "No" based on the CTC-1 card and the caregiver's response. Tick "N/A" if the child has been on ART for less than 6 consecutive months.

Part D: Issue referral

Issue a referral for any of the following conditions:

- If any responses to questions 3-20 are ticked "Yes,"→ Issue referral
- If any responses to questions 21-27 are ticked "No"→ Issue referral

Provide assurance that during the process of HIV testing and counselling as well as care and treatment, the following will always be adhered to by health care workers:

- Confidentiality
- Accurate and sufficient counseling sessions and information on HIV/AIDS
- Standard operating procedures
- Linkages to other services as needed

Identify a health facility close to the beneficiary's household that offers HIV services. Issue the referral and indicate on the HIV Risk, Services, and Adherence Assessment that the beneficiary was referred.

If the referral has been issued, write the referral's serial number as indicated in the referral form.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