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OPERATIONS MANUAL

For The National Case Management System
For Welfare And Protection Of Children In Zimbabwe



Zimbabwe
Ministry of Public Service, Labour and Social Welfare
(Department of Child Welfare and Protection Services)



National Action Plan for
Orphans and Vulnerable Children



Operations Manual
For The National Case Management System
For Welfare and Protection of Children in Zimbabwe
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Acronyms

ACRWC	African Charter on the Rights and Welfare of the Child
BEAM	Basic Education Assistance Module
CBO	Community Based Organization
CCWs	Community Case Workers
CLCPC	Child Led Child Protection Committee
CMO	Case Management Officer
CPC	Child Protection Committee
CSW	Council of Social Workers
DCWPS	Department of Child Welfare and Probation Services
DCWPSO	District Child Welfare and Probation Services Officer
DSS	Department of Social Services
FBO	Faith Based Organization
JSC	Judicial Service Commission
LCCW	Lead Child Case Worker
MIS	Management Information System
MoPSLSW	Ministry of Public Service, Labour and Social Welfare
MSCPHA	Minimum standards for Child Protection in Humanitarian Action
NAC	National AIDS Council
NAP	National Action Plan
NASW	National Association of Social Workers
NCMS	National Case Management System
NGOS	Non-Governmental Organizations
OVC	Orphans and Vulnerable Children
PCWPSO	Provincial Child Welfare and Probation Services Officer
UNICEF	United Nations Children's Fund
UNCRC	United Nations Convention on the Rights of the Child
VFU	Victim Friendly Unit
VHW	Village Health Worker
WAAC	Ward AIDS Action Committee
WEI	World Education Incorporated

Definitions of Key Terms

Assessment:	The systematic process of gathering information to provide a comprehensive understanding of a child and their environment.
Care Plan:	The articulated set of actions to be taken based on the findings of the assessment in order to provide care to the child.
Case:	Each individual child who is identified as vulnerable and potentially in need of services.
Case Conference:	A meeting of multiple, relevant stakeholders or family members to share information and prepare a comprehensive care plan for a child.
Case File:	The written record that compiles all information on a child.
Case Manager:	The person responsible for making sure that a child receives all of the services which they need.
Case Management:	"...collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes" ¹ .
Case Review:	A periodic evaluation of the care plan based on ongoing assessment of the child and the child's situation.
Child:	Section 81(1) of the Constitution of Zimbabwe defines a child as every boy and girl under the age of eighteen years.
Child Protection:	A set of services and mechanisms put in place to prevent and respond to violence, abuse, exploitation and neglect, which threaten the well-being of children.

Child Protection Committee (CPC):	Multi-sectoral and multi-stakeholder structures put in place at national and sub-national levels to coordinate implementation of child protection interventions at each level.
Community Case Worker (CCW):	A cadre selected at the community level from village Child Protection Committees (child protection structures) to identify vulnerable children in their communities.
Confidentiality:	The duty to respect the privacy of information shared by and about children and families.
Family group conference:	A meeting in which family members come together to share information, to plan and make decisions on a child who is at risk.
Intake:	The systematic method of collecting basic information on a child who has been identified as potentially at risk.
Orphan:	A child age 0 – 18 for whom one or both parents has died.
Referral:	The process of connecting a child to a specific service provider to address an identified need.
Supervision:	The process of providing oversight and support to the individuals engaged in service delivery to ensure quality care.
Vulnerable child:	A child who is living in circumstances with high risks and whose prospects for continued growth and development are seriously threatened.

Chapter 1:

Foundation of the National Case Management System



Section 1: Introduction

The complex social, economic and political challenges that have confronted Zimbabwe for the last decade have resulted in increased numbers of vulnerable households and families. Statistics indicate that an estimated 1.5 million households in Zimbabwe are extremely poor and food insecure². The HIV/AIDS pandemic has interacted with and aggravated these socio economic challenges. As a result of this pandemic, an estimated 1.6 million children, including 1.0 million who have lost one or both parents, have been made vulnerable by the HIV and AIDS epidemic.

These children live below the poverty datum line and one in three of these children suffer from chronic malnutrition. Additionally, many of these children are unable enroll and stay in school because of their inability to afford the tuition fees, the uniform and other associated costs.³ Further, violence and abuse of children is on the increase with 60% of reported rape survivors being children and the majority of them are girls.⁴ One in eight girls is reportedly being sexually harassed at school and 22% of children are reportedly being abused by care givers.

It is against this background of challenges faced by children, that 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 vulnerable children. The Program of Support (PoS) under the National Action Plan for Orphans and Vulnerable Children Phase 1 reached 410,000 OVC with an average of 1.6 services per child. A review of the national programme found that while this programme was highly relevant, efficient and cost effective there were a number of key problems which included:

- The fragmented nature of the programme (OVC suffer many types of deprivation, but the PoS offered only 1 or 2 types of support to each child),The programme focused on reach (number of children served) rather than the quality of the service provided,
- Coordination at province, district and ward levels was often ineffective and the then Department of Social Services staff should have been more involved in quality assurance.⁵

²The Case Management Society of America (CMSA)

² ZIMVAC (2010)

³ Government of Zimbabwe (2010), Millennium Development Goals Report

⁴ Victim Friendly Unit Police Reports (2008 – 2010)

⁵ JIMAT Development Consultants (2010); Outcome Assessment of the PoS for the NAP for OVC

The findings of the Outcome Assessment of the PoS coupled with the situation on the ground provided compelling evidence of the need for a programmatic approach that is evidence based and provides holistic rather than fragmented services and facilitates partnerships to ensure quality and sustainable service delivery.


The increasing trend globally is to address these complex problems using a case management systems approach. In developing a strategy for the management of the complex issues facing children in the country, Zimbabwe looked to the emerging models of case management. The then Department of Social Service (DSS), now the Department of Child Welfare and Probation Services (DCWPS) in Zimbabwe, chose to adopt the Isibindi Model from South Africa, a model that sought to strengthen the South African child protection system by linking HIV/AIDS and child protection programming at community level. It is a model that, for Zimbabwe, promoted drawing on and building Zimbabwe's existing pool of Child Protection Committee (CPC) volunteers to form their extension worker cadre: the Community Case Worker (CCW), and enabled existing structures to be streamlined and formally linked with the DCWPS.

Hence, the National Case Management System (NCMS) was conceived as a viable approach to addressing identified needs for children and gaps in available services. The system is grounded in existing national and international legal and policy frameworks. Zimbabwe's Children's Act⁶ serves as the primary legislation that provides for the care and protection of children in the country. Further, Zimbabwe ratified both the United Nation Convention on the Rights of the Child (UNCRC) (1989) and the African Charter on the Rights and Welfare of the Child (ACRWC) (1990) and it boasts of a detailed legislative framework that promotes the rights and interests of children. Although these protective laws and policies have existed for some time in Zimbabwe, there has been a need for a system to guide the way in which vulnerable children can access quality services and be supported within a continuum of care. In response to this need, the Ministry of Public Service, Labour and Social Welfare developed this NCMS for the purpose of facilitating the response to the social welfare needs of the most deprived and vulnerable children and families, and supporting the coordination of replicable service delivery at community level.

The National Case Management System for the Welfare and Protection of Children in Zimbabwe⁷(NCMS) was finalized in 2014. This operations manual accompanies the systems document and further expands on the concepts put forth. It serves as the primary, detailed guide for the implementation of the system. These implementation guidelines are for the purpose of standardizing and coordinating the multi-sectoral

⁶Children's Act (Chapter 5:06)

⁷ Ministry of Public Service, Labour and Social Welfare, 2014



system of care for vulnerable children in Zimbabwe. Additional information for maximum engagement in the system can be found in the Training Manual of the NCMS⁸ and the NCMS Support Supervision Training Manual.⁹

⁸ Ministry of Public Service, Labour and Social Welfare, 2014

⁹ Ministry of Public Service, Labour and Social Welfare, 2014

Section 2: Case Management: What and Why in Zimbabwe

Case management is an approach to care that is, by definition, a collaborative process that maximizes the effective use of resources through identification, communication and coordination of care. It is a process that rests on the assessment of an individual in the context of their family and larger environment, plans care based on a comprehensive assessment and then implements the care through the coordination of services offered by a range of service providers on governmental and non-governmental levels.

In the context of Zimbabwe, the case management system is aligned to the Government's child-sensitive social protection framework approach under Zimbabwe's National Action Plan (NAP II) for Orphans and Vulnerable Children (OVC). It is the national mechanism for the response, mitigation, and prevention of all risks to the protection, well-being and safeguarding of the children of Zimbabwe. This NCMS leverages on the prevalent culture of care and support inherent in Zimbabwean communities to identify hard to reach orphans and vulnerable children and provide them with critical interventions at their point of need.

From a regulatory perspective, the NCMS is the Government of Zimbabwe's framework for the definition and co-ordination of all child care and protection services and service providers. It defines the core values, principles, and beliefs that undergird and guide all initiatives undertaken by stakeholders in fulfilling the country's commitment to protecting and safeguarding children; as guaranteed by Zimbabwean legislation.

Section 3: Vision, Goal, Objectives and Principles of the NCMS

Vision

The Government of Zimbabwe's vision is that all children live in safe, secure and supportive environments that are conducive to child growth and development.

Goal

A harmonized and standardized systematic framework for the care and protection of children that provides access to social welfare, social protection, justice and health services.

Objectives

The objectives of the NCMS are to:

- i. establish a standardised 'wrap-around' response service system that protects children from abuse, violence, exploitation and neglect within a coordinated continuum of care;
- ii. strengthen child protection systems through linkages of community child protection and the formal system;
- iii. reduce children's exposure to harm through actions that strengthen the protective environment for children in all settings;
- iv. provide a system of care planning and coordinated implementation that links children, families and agencies in order to optimally address safety, health and developmental needs of a child;
- v. establish a system for knowledge management, monitoring and promotion of quality child protection services informed by ethics and standards of practice.

Section 4: Guiding Principles

The government of Zimbabwe has ratified the UNCRC¹⁰, and the ACRWC.¹¹ The principles articulated in these and in Zimbabwe's Children's Act¹² are included in the Constitution of Zimbabwe, adopted in 2013. The rights and principles spelled out in these documents form the foundation for all work with children in Zimbabwe. Particularly pertinent to child protective work are the following:

- Non-discrimination (Article 3)
- Best interests of the Child (Article 4)
- Right to survival and development (Article 5)
- Protection from child abuse (Article 16) and sexual abuse and exploitation (Article 27)
- Protection of a child separated from parents (Article 25)

These fundamental rights, supported by the principles of case management and the basic ethical principles of respect, beneficence, no maleficence and justice, provide the foundation on which all care and protection of children rests.

Further, the NCMS 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. They are family centered and build on strengths as a way to address challenges and problems.

¹⁰ United Nations Convention of the Rights of the Child, 1989

¹¹ African Charter on the Rights and Welfare of the Child, 1990

¹² Children's Act (Chapter 5:06), Law Development Commission, Zimbabwe, 1079

Principles of case management¹³

Do No Harm	Ensure that actions and interventions designed to support the child (and their family) do not expose them to further harm. For example, intervening to help one child can cause conflict between individuals, families and communities and unless care is taken, this may expose a child and her family to further harm. Another example is when the case worker lacks the necessary skills or knowledge to carry out the work or conduct an interview in an appropriate way and therefore, when trying to help a child who has been abused, is putting the child in further distress.
Prioritise the Best Interests of the Child	The term “best interests of the child” broadly refers to a child’s wellbeing. In line with Article 3 of the United Nations Convention on the Rights of the Child (CRC), the best interests of the child should provide the basis for all decisions and actions taken, and for the way in which service providers interact with children and their families. This is important because often in child protection there is no one “ideal” solution possible, but rather a series of more or less acceptable choices.
Ensure Accountability	Accountability refers to being responsible and taking responsibility for one’s actions – as an agency and as staff involved in case management. Agencies and individuals implementing case management must comply with the national legal and policy framework. They will also have to comply with professional codes of conduct where these exist. Agencies introducing or supporting case management as an approach must take responsibility for the initial training, on-going capacity building and regular supervision of staff to ensure appropriate quality of care. This also includes providing children and their families with opportunities to give feedback on the support and services they have received.
Based on Sound Knowledge of Child Development & Child Rights	Assessments and interventions must be made on the basis of knowledge about child development and child protection (such as understanding vulnerabilities and risk factors, and family dynamics), including an awareness of the special needs of girls, children with disabilities and children from rural areas, who are disproportionately affected by violence and abuse, who face barriers or are conventionally discouraged in freely expressing their opinions and views.

¹³ The Global Child Protection Working Group, 2012

Child's right to be heard and views taken seriously	Children have a right to be consulted and their opinions sought and taken into account in decisions and matters which affect their lives. Where it is in the best interests of the child and will not expose the child to further harm, agencies and caseworkers should promote the full participation of the child during case management up until case closure. Involving children in planning and decision-making regarding their own care can be critical in terms of helping them develop their resilience. For children who have suffered from any form of abuse or exploitation, and have experienced a loss of power or control in their lives, it can be an important and empowering stage in the recovery process.
Provide Culturally Appropriate Processes and Services	Caseworkers and agencies should recognize and respect diversity (for example ethnic, cultural, linguistic and religious) in the communities where they work and be aware of individual, family, group and community differences. This is important to be able to make an informed and holistic assessment of a child's situation.
Seek Informed Consent and/or Informed Assent	<p>Informed consent is the voluntary agreement of an individual who has the capacity to give consent, and who exercises free choice. In all circumstances, consent should be sought from children and their families / caregivers. To provide "informed consent", the child must be able to understand, and take a decision regarding their own situation.</p> <p>Informed assent is the expressed willingness to participate in services. For younger children who are by definition too young to give informed consent, but old enough to understand and agree to participate in services, the child's "informed assent" is sought. Informed assent is the expressed willingness of the child to participate in services. Even for very young children (those under 5 years old) efforts should be made to explain in simple language appropriate to their age, what information is being sought, what it will be used for, and how it will be shared.</p> <p>It is important to note that in some situations, informed consent may not be possible or may be refused, and yet intervention may still be necessary to protect the child. For example if a 12 year old girl is being sexually abused by her father she may feel loyalty to him and her family and not want to progress any action. That does not mean that agencies can ignore what is happening. Where consent is not given, and where the agencies involved have a legal mandate to take actions to protect a child, the reasons for this should be explained and the participation of children and families continually encouraged.</p>

Respecting Confidentiality & Sharing Information on a Need to Know Basis	Confidentiality is the process whereby information is protected against it falling into the wrong hands and is accessible only to those authorized to access it. Confidentiality is linked to sharing information on a need to know basis. For agencies and caseworkers involved in case management, it means collecting, keeping and sharing information on individual cases in a safe way. Workers should not reveal the names of children who are receiving a service or provide personal information on cases to anyone not involved in the care of the child. The term "need to know" describes the limiting of information that is considered very sensitive, and sharing it only with those individuals who need the information in order to be able to support efforts to protect the child. This can be especially challenging with other colleagues in the office who may be naturally curious and interested in the work.
Working in a Non-Discriminatory Way	Discrimination means treating a child differently because of their individual characteristics or a group they belong to (for example, gender, age, socio-economic background, race, religion, ethnicity, disability, sexual orientation or gender identity). Children in need of protective services should receive assistance from agencies and caseworkers who are trained and skilled to form respectful and non-discriminatory relationships with them, treating them with compassion, empathy and care. Whether engaged in awareness-raising, prevention or response activities agencies and case workers should challenge discrimination, including policies and practices that reinforce discrimination.
Maintaining Professional Boundaries & Addressing Conflicts of Interest	Caseworkers and agencies should act with integrity by not abusing the power or the trust of the child or their family. This includes not asking for favours or payments in exchange for unfair advantage or services. Personal and professional limitations and boundaries must be recognized and respected. Steps should be taken to address conflicts of interest where these arise. An example of a conflict of interest might be where the caseworker and child are in some way related or from the same social network, or where the caseworker working with the child is also the caseworker for the perpetrator of the abuse.

Adherence to these principles serves as a guide for interactions with children and families. Utilizing these will maximize quality care to children and families in need, keeping the child and the family at the center of care at all times. Additionally, these principles serve as a guide for providers as they assess the care that has been provided to a child, and their own actions and approaches in doing so.

Chapter 2:

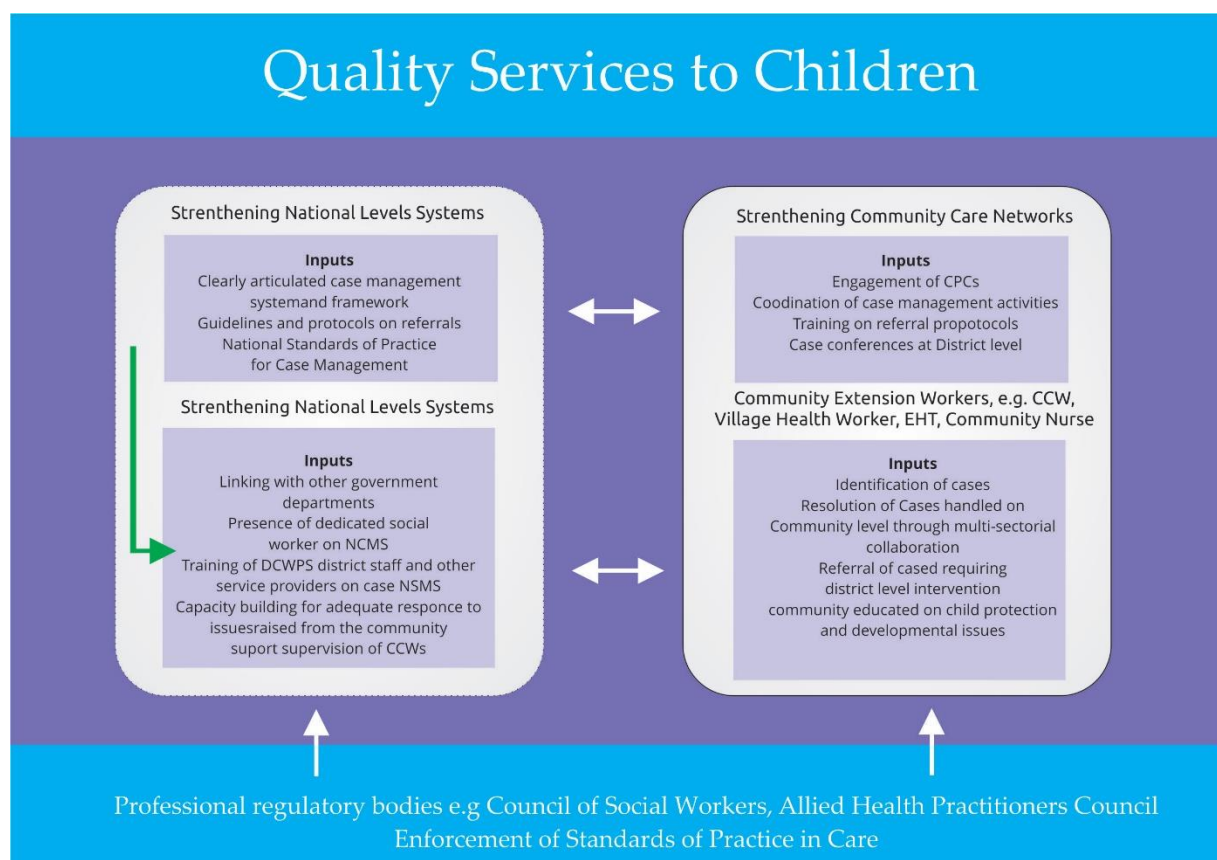
The Case Management System Approach



SECTION 1: CONCEPTUAL FRAMEWORK

Case management is a way of organizing and carrying out work so that children's cases are handled in an appropriate, systematic and timely manner. It aims to ensure that through coordinated, collaborative care, children can receive the services they need. The case management model, therefore, describes the system of coordination and management of specific national, provincial, district and community level actors working together for the specific goal of quality service provision to children in need of care and protection. This National Case Management System is designed in such a way as to support replicable service delivery at all levels.

Figure 1. Conceptual framework



In the NCMS model, the State, which holds the overall mandate for protection of children, functions in collaboration with clearly structured and targeted community participation. The model adopts a two-pillar approach to ensure the effective

channelling of cases and information between and among all levels of child protection service provision: national, sub-national and community levels. It is focused on strengthening the capacity of these two critical arms (DCWPS and community), linking services to timely and effective interventions from case identification to case closure.

The national pillar:

- focuses on capacity building and systems strengthening for case management processes within the Department of Child Welfare and Probation Services (DCWPS);
- is supported by a clearly articulated framework that is sequentially cascaded to all operational levels.

The Community Care Networks pillar rests on:

- the essential role played by Child Protection Committees (CPCs) and Community Case Workers (CCWs) who function on the ground as an extension of the DCWPS; and
- the active participation of community based care providers in child protection service delivery.

It is important that participants in both pillars:

- understand their role as part of the larger system;
- carry out their responsibilities in collaboration with the other players in the system;
- practice open communication to ensure the requisite flow of information necessary to providing comprehensive services to a child and family.

The actions of providers in both pillars is governed by standards of practice articulated by the professional regulatory body for their discipline and by professionally endorsed ethical practices.

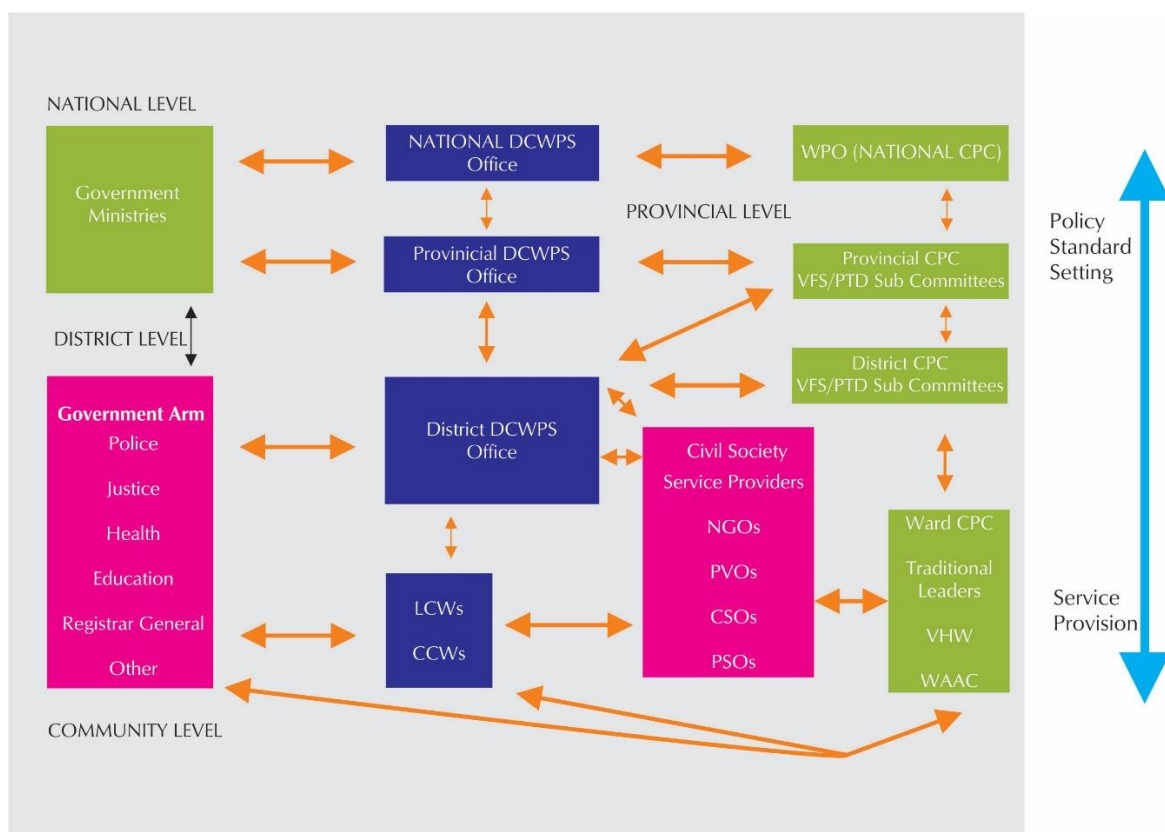


Figure 2. Structure of the case management system

The structure of the NCMS is comprised of the DCWPS, which holds a central role in the protection of children, and a range of governmental and non-governmental stakeholders. Clear lines of communication and coordination of care between the various sectors are essential to the functioning of the system. The system is structured such that children are identified and cared for on the community level in all ways possible.

This care is provided by a variety of stakeholders, depending on specific need. Implementation of care requires coordination by the CCW, who is a member of the local CPC. All cases involving any form of abuse are immediately referred to the DCWPS and the child's care becomes the primary responsibility of the DCWPS. Care will continue on the community level as directed by the case manager in the DCWPS. Cases that are particularly complicated, or require statutory intervention may be passed up to district level for necessary care.

In addition to the provision of direct care, stakeholders hold the responsibility of developing, promoting, and/or enforcing policy and standards of practice. Policy development and decision making is primarily done at the national and provincial levels. It is carried out by various stakeholders, depending on the issue at hand.

Stakeholders on this level include: government ministries; district and national level DCWPS; district and provincial CPCs and the Working Party of Officials (WPO); the Victim Friendly System Sub-Committee (VFS) and Pre-Trial Diversion Sub-Committee (PTD). Various civil society service providers may also be involved on the provincial and national level with regards to policy and practice decisions.

The effective functioning of the NCMS relies on the consistent communication of information on all levels. Generally, the information on service delivery starts in the community level and flows upwards. It is essential, however, that feedback and follow-up on relevant issues flow back down to appropriate stakeholders. Likewise, though policy issues are formalized on the upper levels, they are developed in response to information from community and district levels. Completion of the information sharing cycle through communication of these policies downwards is essential. In short, there is a need for constant sharing of information within and between the various stakeholders and the multiple levels of the system.

Section 2: Multi-Sectorial Players; Roles and Responsibilities of Key Government Stakeholders

The success of the Case Management Model in Zimbabwe hinges heavily on the use of all available resources, including those at the community level and the various government structures at community, district and provincial levels. All stakeholders need to be aware of the availability, roles and responsibilities of other stakeholders.

Ministry of Public Service, Labour and Social Welfare. The Department Of Child Welfare and Probation Services (DCWPS)

The DCWPS, has the lead statutory mandate for the protection and safeguarding children as provided by the Children's Act (Chapter 5:06). As such, Department of Child Welfare and Probation Services Officers hold the responsibility for guiding case management and are ultimately responsible for work carried out on lower levels. The DCWPS has the responsibility of setting the parameters for cases that can be managed at the community level and the cases that, at all times, should be managed at the District level. Cases of child sexual abuse, are an example of cases that require the expert support of the DCWPS. While CCWs can provide support to the child under the guidance of the DCWPSO, direct involvement of the District Child Welfare and Probation Services Officers (DCWPSO) is mandatory in ensuring that the child has access to protection and justice.

Functions and responsibilities of the DCWPS social workers in case management are to:

- serve as the government arm with the overall statutory mandate for child protection and safeguarding;
- provide standards and guidelines on the appropriate and mandatory response to allegations of abuse and other child protection concerns;
- investigate and intervene in cases of alleged abuse;
- assist the courts through the provision of case reports in responding to child protection issues;

- provide direct services to children and families in complex or high risk cases that cannot be adequately handled at the community level;
- coordinate all case management processes;
- coordinate all case management actors;
- provide technical backstopping for all case management actors;
- support the work of CPCs and CCWs;
- conduct ongoing care plan reviews of the work of CCWs;
- ensure that CCWs maintain the necessary support to children throughout the duration of the case;
- advocate for the acceptance and processing of all referrals to other agencies;
- maintain and review care plans and case records;
- providing pre-trial and post-trial support to children who are victims of crimes and children who come into conflict with the law;
- assisting young offenders in accessing rehabilitative services;
- house and maintaining the Management Information System (MIS).

Additionally, an important role of DCWPS social workers in child protection is the mandate to serve as probation officers¹⁴ with the specific responsibilities of¹⁵:

- removing children from a place of harm to a place of safety;
- writing court reports to support children in conflict with the law, narrating the circumstances of children facing charges;
- providing observation of children facing correctional services;
- supervising and controlling any person placed under the supervision of a PO;
- monitoring places of entertainment to inspect the activities for the purpose of ensuring the safety of children;
- facilitating and supporting fostering and adoption of children.

Child Protection Committees (CPCs) Structures

The Department of Social Services works in partnership with all agencies that are involved in child welfare work. Representatives of these agencies are required to be part of the Child Protection Committees. CPCs are multi-sectoral and multi-stakeholder

¹⁴Children's Act, section 46 (1)

¹⁵Training Manual/Handbook on Child Care and Protection, The Department of Social Services, Ministry of Public Service, Labour and Social Welfare, 2010.

structures put in place at national and sub-national levels to coordinate implementation of child protection and safeguarding interventions by various players at each level¹⁶. There are 4 levels of CPCs: community/ward level; district level; provincial level; and national level. Each level has its role and function within the CPC structure.

The broader functions of CPCs within the Case Management framework are to;

- identify child protection concerns at ward and village levels;
- provide front-line responses to child protection concerns;
- coordinate responses to and monitoring of child protection concerns at the district level;
- advocate with local authorities, government institutions, the private sector and donors to prioritise commitment of resources to NAP activities and ensure close collaboration among stakeholders;
- Meet regularly to discuss child rights, including issues on policy, legislation and programmes by stakeholders; and
- on the national level, focus on policy related matters arising from the community, ward, district and provincial level CPCs.

A full description of the structure, roles and responsibilities of the CPCs at the different levels can be found in the Child Protection Committee Protocol.¹⁷ Included in this protocol is guidance for selecting CPC members. In short, the overall selection criteria are as follows:

- Keen and genuine interest in and basic knowledge about children's issues and welfare
- Intrinsic protective love for children
- Passion for children's rights and an ability to learn new concepts of child protection
- Have no prejudices against different groups of children e.g. children with disabilities
- Willingness to volunteer services beyond the ordinary expectations
- Possession of basic counselling skills or have the capacity to learn
- A level of education that enables the person to maximize use of trainings or continuing education
- Ability to maintain confidentiality
- Respected by the community

¹⁶Coordinator's Partnership Management Workbook, Version 1. 2006-2010, Ministry of Public Service, Labour and Social Welfare

¹⁷Child Protection Committees Protocol, Ministry of Public Service, Labour and Social Welfare

Levels of CPCs

On the **community level**, the members of the CPCs are chosen locally by the community. Representation is sought by a range of individuals, both people who play key roles with children in the community, and people who possess the personal qualities outlined in the selection criteria. The primary functions on the community level are to:

- identify vulnerable children in the community; catalogue these children in the village OVC register.
- select, monitor and support the Child Care Workers (CCW).
- ensure that child abuse is reported to the relevant authorities and that appropriate action is pursued.
- maximize the use of resources to meet the needs of vulnerable children.
- share information with and report to the district level CPC on what is happening with children on the ground.

On the **district level**, the primary function of the CPCs is to collect and summarize information from the community/area level CPCs. This information includes statistics of cases of child protection handled at community and area levels, levels of participation, challenges faced in the communities in regards to child protection issues and services, etc. The district level CPCs may also receive child protection cases that the community and ward level CPCs have not been able to address.

The function of the **provincial level** CPC is more focused on coordination and providing information to national level processes. As such, they receive the reports generated by the district level CPCs, and help develop creative strategies for addressing challenges identified. Additionally, provincial level CPCs act on behalf of CPCs from the community and the district levels. They receive the more complex cases of child protection.

Representation on CPCs

Membership of CPCs should include the following government line ministries and departments: Education, Health, Justice, Home Affairs, Public Service, Labour and Social Welfare, and local Government. These key ministries should always be part of the CPCs because the functions they perform are related to children.¹⁸

¹⁸ Child Protection Committees Protocol, Ministry of Public Service, Labour and Social Welfare

Community/area/ward level	District level	Provincial/District	National level
Headman/Village heads Ward councillor Community Workers (health, education, Agritex and other line ministries) Teachers Business people Elected members of the community FBO representation CBO members Child representation from Child led CPCs NGO representatives Traditional Healers NAC ZRP	District Administrator's office Department of Social Services District Council / Municipality community service department Line Ministries e.g. Health, education, Youth, Gender, Agriculture Parliamentary constituency information office NAC Child representation Registrar's office ZRP NGOs and FBOs, Business Community	Provincial Department of Social Services NAC Provincial Registrar General's Department Ministry Of Education Sport and Culture Ministry Of Home Affairs Provincial Administrators' Office Child representation City/Town Council ZRP NGOs FBOs	Working party of officials ¹⁹ i.e. Government line ministries(9) NAC(1) U.N. system (1) Local NGOs (3) –? FBOs (2) National umbrella organisations (1) Z/Red Cross Society (1) Donor organisations (2) Private sector (1) Children (3)

Figure 3: CPC representation²⁰

Children and CPCs

On the international level, child participation in matters that concern them is strongly endorsed. The UNCRC establishes that in keeping with their developmental ability, children have the right to express their views freely in all matters that affect them. Further, it establishes that the child shall be provided the “opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or appropriate body, in a manner consistent with the procedural rules of national law.”²¹

¹⁹ NAP for OVC II

²⁰ Child Protection Committees Protocol, Ministry of Public Service, Labour and Social Welfare

²¹ United Nations Convention of the Rights of the Child, Article 12, 1989

In keeping with these principles, the government of Zimbabwe incorporated children into the framework of the CPCs from their inception. Specifically, there are two forums for children in the CPC framework: child representation on all levels of adult CPCs and Child Led CPCs (CLCPC).

Child Led CPCs (CLCPC)

CLCPCs have been established to encourage the participation of children in matters that affect them. They present a safe environment for children to express themselves without fear of adult ridicule, chastisement or intimidation. They also are meant to provide a forum for children to interact by themselves and support each other in developing their own ways to respond to child abuse in any form. In light of the fact that there have been reports of child abuse cases being identified but swept under the carpet by some adults, CLCPCs need to be provided with information on how to make referrals to either the adult CPCs or DCWPS, in the event the adult system fails them.²²

Levels of Child Led CPCs

On the Village level, CLCPCs play a complementary role to the adult led CPCs. Children within the village come together to discuss areas of common interest around child rights and child protection issues. These CPCs can also advocate on behalf of children whose needs are inadequately met, such as children who are out of school, without birth certificates, etc.. A central person on the adult CPC helps these groups get started and develop, guiding the children on mobilizing, holding meetings, and identifying resource people to present useful topics at their meetings. A focus at this level is awareness raising on child protection related issues and the ways in which the children can act on their own behalf and advocate for each other. Meetings at this level can be as frequent as weekly. At this level, all children have the potential to become CLCPCs members.

For the Ward level, a maximum of 3 representatives, depending on the size of the ward, from village level CLCPCs should be selected to form the ward level CLCPC. The same 3 also report to the village level adult led CPC. The 3 representatives from the different villages meet to take children's issues forward to the ward level.

On the **District level**, a maximum of 2 representatives from the Ward level are selected. These children bring information forward from the Ward to the District level. Likewise, children are selected as representatives from the District level to the **Provincial level**.

²² Child Protection Committees Protocol, Ministry of Public Service, Labour and Social Welfare

From the Provincial level, 3 children are chosen to represent the child's voice at the Working Party of Officials at the **National level**.

Children who are selected to the CLCPCs for representation at the various levels should be ones who demonstrate a commitment to and understanding of child protection issues, leadership skills and the potential to act as advocates for children's rights.

More detailed information on children's roles in the structure and function of CPCs can be found in the Child Protection Committees Protocol.²³

Lead Child Care Workers (LCCW)²⁴

LCCWs are the Community Case Worker (see below) group leaders. They are members of the CPC, and are selected as LCCWs for their leadership qualities. A LCCW manages a group of an average of ten CCWs. The LCCWs are trained to model caregiving to the CCWs and provide overall administrative oversight to the CCWs. LCCWs are the direct link between the community and the DCWPS. The specific functions of the LCCWs include:

- using community based platforms to identify child protection cases;
- profiling, assessing and presenting cases;
- providing the first level of supervision at community level;
- providing support and mentorship to CCWs;
- compiling and presenting the summary sheet of cases at monthly CPC meetings;
- producing and sending monthly reports to the District Social Services Officer.

Community Case Workers (CCWs)²⁵

The CCWs are the voluntary frontline community workers within the Case Management framework. The CCW provides child protection services within communities and are trained to be able to:

- use community based platforms to identify child protection cases;
- profile and assess presenting children and families;

²³ Child Protection Committees Protocol, Ministry of Public Service, Labour and Social Welfare

²⁴ The Lead CCCW is often also the ward CPC Secretary

²⁵ These are members of and are selected by village CPCs. CCWs are volunteers and may therefore not be office bearers in any profession during their tenure as CCCW

- open case files on children identified as being at potential risk;
- conduct assessments of children and families;
- report cases to relevant duty bearers;
- physically support children to access services (walk with a child all the way);
- conduct routine follow up on children;
- advocate with community based stakeholders;
- document & record case information in the case records at the community level;
- liaise with and report to the LCCW

Selection criteria of CCWs:

- Selected by the community and are, or become, members of the local CPC
- Able to communicate clearly both verbally and in writing (in order to complete all necessary record keeping)
- Able to uphold the principle of confidentiality
- Honest and reliable
- Understands and supports the needs of children
- Once determined by the community that a person is appropriate for the position of CCW, he/she is vetted by the police before taking on the role.

The work of the CCWs is governed by the Minimum Standards for Child Care Workers (APPENDIX IV). These standards were developed in collaboration with the DCWPS, social care professionals, CCWs, related Non-Governmental Organizations and other stakeholders, and adopted by the Council of Social Workers (CSW).²⁶ These standards describe the expectations of conduct and practice required of CCWs. Of importance, they establish the requirements of:

- Ability to communicate well with children and families
- Ability to read and write for the purpose of record keeping
- Ability to understand childcare services that are provided within and outside the community
- Sensitivity and ability to understand the feelings and wishes of children and families
- Capacity for education and development in order to provide quality care.
- Ability to serve as a role model for children as they prepare for adulthood

²⁶ The Minimum Standards for Child Care Workers can be obtained through the Council of Social Workers

Ministry of Home Affairs

The Registrar General's Office

The Registrar's office is responsible for birth and death registration. These documents are required to access a range of services. The Registrar's Department:

- works in collaboration with DCWPS to ensure that applications for birth certificates are completed in full;
- provides registration, enabling registration to take place including in remote areas;
- raises awareness on the importance of the documented birth and death certificates.

While Zimbabwe has a clearly documented System for Birth and Death registration, OVCs struggle with the attainment of these documents. This calls for all the players in the NCMS to assist children in getting these documents through referrals to the Registrar's Office and addressing bottlenecks that can affect a child's prospect of getting a birth certificate. Some of these bottlenecks can be due to lack of funds on the part of families making it difficult to make the trip to the Registrar's Office, missing documentation or the absence of the relatives necessary to facilitate the process.

Zimbabwe Republic Police

It is mandatory that known or suspected criminal activity, which includes child abuse, is reported to the police. Not only is keeping silent when there is known abuse or substantial evidence of it, in violation of the law, it goes against the principle of acting in the best interest of the child. It is the role of law enforcement to act on behalf of a victim when a potential crime is reported. Likewise, when the person accused of the crime is a child or adolescent, it is the role of law enforcement to safeguard the rights and needs of that person as well. Whether addressing a victim or perpetrator, acting in the best interest of the child is the guiding principle. To accomplish this, an understanding of, and actions in compliance with law, policy and structures to protect both victims and perpetrators are critical in child protection work.

For children/youth who are the victims of crime:

- Victim Friendly Unit (VFU): this unit was established within the police force specifically to address violence against women and children, particularly sexual offences and domestic violence. They have a special mandate in child protection.

The units, which exist in all police stations, are staffed by police officers who have been specifically trained to deal with cases of child protection. VFU investigators are responsible for:

- a) investigation of all allegations of abuse or criminal violation of a children's rights;
- b) arrest of offenders when there is adequate evidence that a child has been harmed or seriously threatened;
- c) docket compilation and making necessary referrals;
- d) assisting victims with accessing medical examination and treatment;
- e) ensuring that the reporting environment is conducive, private and friendly and that confidentiality is maintained;
- f) protecting the child or other witnesses against manipulation or pressure to alter their statements or accusations;
- g) communicating with DCWPS to ensure the child has maximum protection and support;
- h) removal of the child to a place of safety if deemed necessary, in keeping with guidelines set out in the Children's Act, Part V, 14. (*For further discussion, see Chapter 3: Standard Operating Procedures And Key Processes, Section 1: **Removal of a Child to a Place of Safety.***)
- i) bringing a child whom they remove to a place of safety in front of the court for further determination as soon as possible, but not longer than 7 days (Children's Act, section 17).

For children/youth who are the accused offender, police are responsible for:

- Ensuring that special measures are taken by the investigating officer in liaison with the Probation Officer where the alleged perpetrator is a child, to guarantee that the protocol's guiding principles, including the 'best interest of the child' are applied.²⁷
- Communicating with DCWPS to ensure the child has maximum protection and support;
- Pre-trial diversion for young persons: if a person accused of committing a crime is 21 years or below, admits to the crime, and the crime is one that would not typically receive more than a one year sentence, then the Pre-Trial Diversion guidelines should be used.²⁸ Principles articulated in these guidelines that give direction to police include:

²⁷Protocol on the Multi-sectoral on the Management of Sexual Abuse and Violence in Zimbabwe, Judicial Service Commission, 2012.

²⁸Zimbabwe Pre-Trial Diversion Program for Young Persons, Government of Zimbabwe, 2012.

- a) Assessment of the youth prior to arrest. If reasonable, have the child accompany the police to a place conducive for assessment;
- b) Prior to or after an arrest, if initial assessment suggests that the criteria for pre-trial diversion are likely met, a diversion officer should immediately be contacted;
- c) Contact parents, guardian or other appropriate adult as quickly as possible;
- d) If arrested, notify the probation officer within 12 hours;
- e) Detention is to be used as a last resort.
- f) For the full details of responsibility, police should consult the Pre-Trial Diversion Program Guidelines.

Ministry of Justice Legal and Parliamentary Affairs

The Children's Act (Chapter 5:06) was enacted in part to provide for children's courts, courts that specifically "make provision for the protection, welfare and supervision of children and juveniles."²⁹ Likewise, the ACRWC states that "every child accused of or found guilty of having infringed penal law shall have the right to special treatment in a manner consistent with the child's sense of dignity and worth and which reinforces the child's respect for human rights and fundamental freedoms of others."³⁰ The Ministry of Justice, Legal and Parliamentary Affairs is charged with protecting the legal rights of both victims and accused perpetrators of crimes. This involves both parties having the opportunity to have their views and experiences heard without undue pressure or judgment.

The Ministry has developed Children's Court/Victim Friendly Courts to ensure that children and witnesses are protected from further harm as they engage with the legal system. Guidelines for working with victims of sexual crimes are detailed in the Protocol on the Multi-Sectoral Management of Sexual Abuse and Violence.³¹ It is the responsibility of the court to:

- Provide children and witnesses the opportunity to give their statements in a separate room;
- Help the child understand the court process and receive support by providing a Court Interpreter;

²⁹ Children's Act (Chapter 5:06), Law Development Commission, Zimbabwe, 1079

³⁰ ACRWC (Article 17), 1999.

³¹ Protocol on the Multi-sectoral on the Management of Sexual Abuse and Violence in Zimbabwe, Judicial Service Commission, 2012.

- Protect the child from undue pressure or aggressive questioning during examination and cross examination;
- If the victim, protect the child from further contact with the perpetrator;
- Public Prosecutors should keep case workers informed of case proceedings, enabling them to provide pre-trial and post-trial support to the child, whether the child is the victim or perpetrator of the crime;
- Remove the child to a place of safety if deemed necessary, in keeping with guidelines set out in the Children's Act, Part V, 14. (*For further discussion, see Chapter 3: Standard Operating Procedures and Key Processes, Section 1: Removal of a Child to a Place of Safety.*)
- Post-trial support: ensuring that children who have been involved with the justice system are referred for counselling or other appropriate psychosocial support.

For children who are accused of a crime the court holds specific responsibilities. These include:

- Adhering to Pre-trial Diversion Program Guidelines in all applicable cases;
- Convening a Diversion Committee in every province;
- Giving special attention to sentencing, considering age and circumstances in addition to the severity of the crime. Sentencing should be conducted in keeping with guidelines from the National Prosecuting Authority, established by the Constitution of Zimbabwe.
- Post-trial support: ensuring that children who have been involved with the justice system are referred for counselling or other appropriate psychosocial support.

Additionally, the legal system carries responsibility for civil issues that have significant bearing on children. These include issues pertaining to adoption, custody, and inheritance.

Department of Prisons and Correctional Services:

The Department of Prisons and Correctional Services should immediately notify probation officers whenever a child's protection is at risk due to their own or their parent's contact with this Department. In instances where a child is being cared for in prison by their incarcerated mother the Department of Prisons and Correctional Services should liaise with the DCWPS in order to place the child in a place of safety and jointly formulate care and reunification plans.

In any case where an offender is considered to pose a risk to children, social services in the area where he lives (or intends to live in the case of prisoners) should be alerted. All agencies working with sex offenders including the probation service, the prison service, the police and social services should assess the risk posed to children by sex offenders.

Ministry Of Primary Ond Secondary Education

The Education Act³² identifies education as a fundamental right of children in Zimbabwe and it is the responsibility of those who care for the child to ensure that the he or she has access to an education. Educational personnel are amongst those outside of the home who have the closest contact with children. They are in a good position to observe the behaviour and overall functioning of children and provide valuable resources in both the assessment of potentially vulnerable children, as well as serve as sources of support. Any time there is a concern over a child, educational personal should be in contact with the family, to both gain information and determine action to be taken. Their specific responsibilities include:

- Ensuring “child friendly schools”, in which learning environments operate in the best interests of the child and promote optimal development and learning.³³
- Monitoring all children for their ability to engage in developmentally appropriate educational activity;
- Addressing a child’s educational needs and taking action when problems are identified;
- Establishing the reason for a child’s lack of regular attendance at school, and working jointly with appropriate stakeholders to address the barriers;
- Assist with the selection of BEAM beneficiaries;
- Monitor for changes in behaviour, distractibility or other signs that a child may be troubled by occurrences in their life and take appropriate action.
- Discuss any concerns with supervisors or other appropriate parties who know the child or who are in decision making positions regarding reporting of suspected child protection needs;
- Discuss concerns with family members as appropriate;
- Reporting any concerning behaviour of a child who is under the supervision of a probation officer to DCWPS;
- Develop, implement and monitor policies and programs to support optimal development;

³² Education Act (Chapter 25:04), Government of Zimbabwe, 2001.

³³ UNICEF, www.unicef.org/cfs, 2013

- Communicate with local CPC's if there are concerns that a child is vulnerable and in need of services;
- Provide DCWPS with timely progress reports on children under the care of the state;
- Removal of a child to a place of safety if necessary, with subsequent report of the removal to DCWPS probation officer within 5 days of the removal in keeping with guidelines set out in the Children's Act.³⁴. (For further discussion, see Chapter 3: Standard Operating Procedures and Key Processes, Section 1: **Removal of a Child to a Place of Safety.**)

Schools are encouraged to have a Case Management focal person or designated teacher who shall receive appropriate training and be responsible for Case Management in the school.

Ministry Of Health and Child Care

Health care workers in a community are involved with children and families, and can provide both information and services. Seeing children for health related issues frequently provides a window into a child's overall functioning and any problems that arise. The roles of medical and mental health providers in child protection services include:

- providing emergency medical treatment for survivors of abuse;
- after providing emergency treatment, refer the abuse survivor to the VFU if this has not already been done;
- the promotion of child health through growth and development screening;
- immunizations;
- education for parents and guardians on children's physical, psychological, social and emotional needs;
- diagnosis and treatment of childhood illnesses, including physical and mental health;
- screening and assessment of children seen in health care settings, including emergency as well as routine care settings, for signs of abuse or neglect;
- notification of DCWPS by hospital personnel of the presence of abandoned children within their institution;
- communication with other relevant stakeholders when abuse is suspected;

³⁴Children's Act (Chapter 5:06), Part V, 14, Law Development Commission, Zimbabwe, 1079.

- removal of a child to a place of safety if necessary, with subsequent report of the removal to DCWPS probation officer within 5 days of the removal in keeping with guidelines set out in the Children's Act.³⁵ (For further discussion, see Chapter 3: *Standard Operating Procedures And Key Processes, Section 1: Removal of a Child to a Place of Safety.*)
- physical and psychological treatment of children who have been abused;
- provision of the medical, social and psychological perspective in assessment and care planning;
- provision of information from health assessments.

National Aids Council (NAC)

The National AIDS Council coordinates the multi-sectoral response to HIV in Zimbabwe. Their program areas include prevention, mitigation, treatment and support. Working under the guidance of Zimbabwe's NAPII, the estimated 1.6 million children made vulnerable by HIV are a population of focus. The role of NAC as a multi-sectoral partner in the case management system includes:

- Providing structures that link with the DSS structures on Case Management, e.g. Ward, District and Provincial Aids Action Committees' (WAACs, DAACs', PAACs'); Behaviour Change programmes; In and Out of School programmes;
- Assisting by identifying stakeholders working in the HIV sector at all levels who can assist with case identification;
- Provide M & E information on cases of child abuse;
- Resource allocation;
- Contribute to mitigation programmes, e.g. BEAM, PSS;
- Provide education/awareness materials to increase knowledge on HIV and AIDS as it relates to the health of children and to child abuse.

³⁵Children's Act (Chapter 5:06), Part V, 14, Law Development Commission, Zimbabwe, 1079.

Section 3: Multi-Sectoral Players; Roles and Responsibilities of Civil Society Organizations

Civil society organizations are critical in the case management system in complimenting government efforts through provision of specialist child protection services. The civil society organizations should work within the case management system guidelines.

Non-Governmental Organizations (NGOs) -

There are numerous NGOs throughout Zimbabwe that provide care, often in the form of specialized service areas that is needed by vulnerable children and their families. Accessing these services and coordinating them with other available services in a community to provide optimal care to a child in need is one of the goals for the NCMS. It is imperative that all services available under their registered mandate are identified by CPCs and care givers when completing the services mapping of their community. Services of NGOs include, but are not limited to:

- Community awareness and social mobilisation;
- Advocacy on child protection issues;
- Capacity building of local child protection structures;
- Identification and referral of cases to relevant stakeholders;
- Advocacy for service provision by the government and other agencies;
- Resource mobilisation to support/complement government services;
- Strengthening and supporting statutory mandate of government systems through capacity building, mentoring and technical back-stopping;
- Provision of specialty services;
- Direct service delivery in the areas of health, psychological and social development, education, support around specific issues including:
 - a) 24 Hour Helpline Services
 - b) Counselling and psychosocial support services
 - c) Medical monitoring and support, e.g. post exposure prophylaxis, forensic examination
 - d) Legal assistance
 - e) Disability services, e.g. rehabilitation, assistive devices
 - f) Support services to children outside the family environment

- g) Support services for children in emergencies
- h) Provision of tangible resources

Private Sector in Corporate Social Investment

The National Case Management System recognizes private businesses who engage in philanthropic work to give back to the communities where they do business. These private businesses should work closely with relevant line ministries, NGOs and other stakeholders to provide resources. Players from the Private Sector should work closely with the local CPC to identify areas of need.

Faith Based Organizations

Faith based organizations are integral to communities throughout Zimbabwe, and often play a role in the lives of individuals and families. They promote values that provide a safe and supportive environment for children. It must be noted that different FBOs have different values, but that all must function within the confines of the law. Areas in which they play a role in the care and protection of children include:

- Promoting knowledge related to child rights within their membership and outside of it in their communities;
- Participation in CPCs and associated capacity building activities;
- Playing an advocacy role in promoting child protection and rights;
- Promoting values that provide a safe and supportive environment for children;
- Developing services for those in their communities who are in need, such as programmes to provide food and clothing; health, education and psychosocial services;
- Identification and monitoring of vulnerable children in their communities, communicating with local CPCs and DCWPS when required in order to meet the needs of a child;
- Running facilitated support groups, self-help and peer support groups.

Traditional leaders

Traditional leaders include village-heads, headmen and chiefs. They are the traditional custodians for children in their area. These positions are positions of power in their communities, and as such, hold great potential for child protection in the community if used appropriately. Their responsibilities include:

- Identification of vulnerable children in their communities;
- Serving as the custodians of OVC registers;
- Communicating with local CPCs and DCWPS regarding any children in their community who are seen as vulnerable;
- Referring high risk cases to the relevant stakeholders and other welfare cases to the CPCs;
- Ensuring that alleged abuse is reported to the VFU;
- Supporting the community structure on child protection, specifically the CPC and CCWs;
- Managing traditional forms of social security and community safe houses;
- Providing guidance to community members regarding maintaining the safety of children in their community;
- Advocacy for child protection and rights;
- Serving as role models in child protection.

Informal systems:

In addition to the formal systems and programs that are in place, informal systems are often some of the most important systems that surround a child and should not be overlooked. These systems include but are not limited to:

- Extended family, local and at a distance
- Neighbours
- Members of church communities
- Peers support
- Traditional healers
- Faith healers
- Traditional birth attendants

Section 4: Step By Step Guide to Setting up a Case Management System in a District

The development of the National Case Management System was designed to ensure the standard provision of services to children across districts. Effectively standardizing the approach is facilitated by a clear understanding on the part of all involved stakeholders of the step by step approach to setting up the system at the District level.

Induction Meeting

An induction meeting is an important prerequisite to starting up the case management system. The purpose of the induction meeting is to orient all DCWPS who are new to case management system. The orientation aims to make sure that there is full understanding of all the requirements for the system. An induction meeting should be designed to provide an overview of the system as well as the steps to follow in the set-up of the NCMS at the District level. An introduction to the Case Management Tool Kit, which is comprised of the National Case Management System, the Operations Manual of the NCMS, and Training Manual of the NCMS, and the Support Supervision Training Manual, is an essential component of the induction.

District Training

Following the induction, there should be a case management training for the District Officers. This training will allow for a detailed understanding of case management and build the ability of participants to steer the process. While the training and mentorship will be ongoing, the NCMS Tool Kit must be provided to equip officers with the prerequisite knowledge and skills necessary to run the system.

Stakeholder Sensitization meetings (District and Community Level)

Stakeholder sensitization at both the District and the Community Level is essential in the setup of the case management system. The aim of these meetings is to bring everyone on board from the beginning. This factor is critical in making sure that the system

functions, given the degree to which the case management system relies on the goodwill of all the players in the system. Stakeholder sensitizations also helps pave the way for the recognition of the role CCWs and the preparation of the District level players for the uptake of cases that will be identified in the community.

CPC engagement

The CPCs are an important pillar in case management and provide a framework through which the CCWs carry out their duties. The engagement of the CPCs at the community and ward level is important to ensure that the CPCs are placed at the core of the National Case management System. This engagement entails explaining the full case management system to the CPCs and outlining the role that the CPCs play in ensuring that the system both begins well and is sustained over time.

Selection and vetting of CCWs

The CCWs are selected from the CPCs. The general selection criteria used to select the CPC members, as outlined in the CPC protocol³⁶, guides the selection of the CCWs. Over and above the general requirements, ability to read and write should also be considered given the amount of documentation involved in the Case Management System. While the selection of the CCWs through the CPCs is a form of vetting, after that selection police vetting should be done for all the CCWs. This level of vetting will ensure that there is an objective way of ensuring that people with past criminal records do not become CCWs.

Training of Case Care Workers

The training of CCWs is meant to ensure that before deployment the CCWs have the requisite knowledge and skills to provide services to children. The training should also be viewed from an ethical perspective of ensuring the minimization of further harm to children through the use of competent care workers. The training of the CCWs should be designed to ensure that they have all the key competencies necessary for working with children and the ability to fulfill the paper work requirements of the system for the tracking that needs to be done in the communities.

³⁶ChildProtection Committees Protocol, Ministry of Public Service, Labour and Social Welfare

Service Mapping Exercise

As part of the setup of the case management system, CCWs, in conjunction with CPCs are mandated to carry out a resource mapping exercise to identify services available to children at both the community and district levels. The exercise will assess the capacity, scope and coverage area of service providers as well as the quality of the services that they offer. The service mapping exercise will also identify the 'informal' and community resources or structures that can be used to support child protection and safeguarding. 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 vulnerable children. It is critical that these informal sources of support are drawn on in the provision of services. Carrying out this exercise provides the CCWs with reference information on the services available in the community and it enables the CCW to be resourceful in accessing services for the children they serve. It is also important to note that the community service mapping can be complemented by the District level service mapping. The District level mapping, through the DCPC can help in further building the awareness of the CCWs to the available services.


Working tools for the Case Care Workers

Provision of working tools should constitute part of the minimum package for CCWs. The working tools, including bicycles, T-shirts, hats, ID Badges and stationery supplies (pens, paper and files) should be provided. These tools will enable the CCWs to function effectively. The DCWPS will regulate and manage the review of these from time to time and ensure that the CCWs are furnished with the necessary tools. Working tools should also be provided in a standardized way across the Districts for easy management of the expectations of the CCWs.

Setting up of Peer Support Supervision Groups

Setting up Peer Support Supervision as guided by the Support Supervision Training Manual³⁷ should be instituted from the beginning. This will allow for the mainstreaming of the supervision concepts from the onset and foster the realization of the goals of support supervision.

³⁷Clinical Supervision Training Manual of the NCMS



The step by step guide to setting up the system provided above should be viewed as a reference framework, with the recognition that the uniqueness of each district, can, at times, make it impossible to follow the guide rigidly. Nonetheless, the setting up of the NCMS should do justice to the general processes described above as they assist in building a firm foundation that will support subsequent processes.

Chapter 3:

Standard Operating Procedures and Key Processes in the CMS



The standard operating procedures and processes are positioned to address the rights and needs of children from case identification to case closure. Case management begins when a concern about a child's well-being is raised and referred to an agency that can take action to safeguard that child.

Once a reason for concern is identified, the child's case enters the step by step process of the case management cycle:

- a. An **intake process** (referral and initial screening) is conducted, which establishes basic information about the child and the reason for the concern.
- b. an initial **assessment** of the child's situation;
- c. **planning** of the interventions that will be necessary to address issues identified during assessment;
- d. **implementation** of the planned intervention in collaboration with the relevant service providers and community case workers; on completion of all planned interventions, a **review** of the child's care plan is conducted; and
- e. When the review concludes that all issues of concern regarding the child's welfare have been addressed, the **case is closed**. Should there be any pending or unresolved concerns, the child will be re-assessed and case managed until their case can be closed.

The following diagram below depicts the process of care in the NCMS described from intake to case closure.

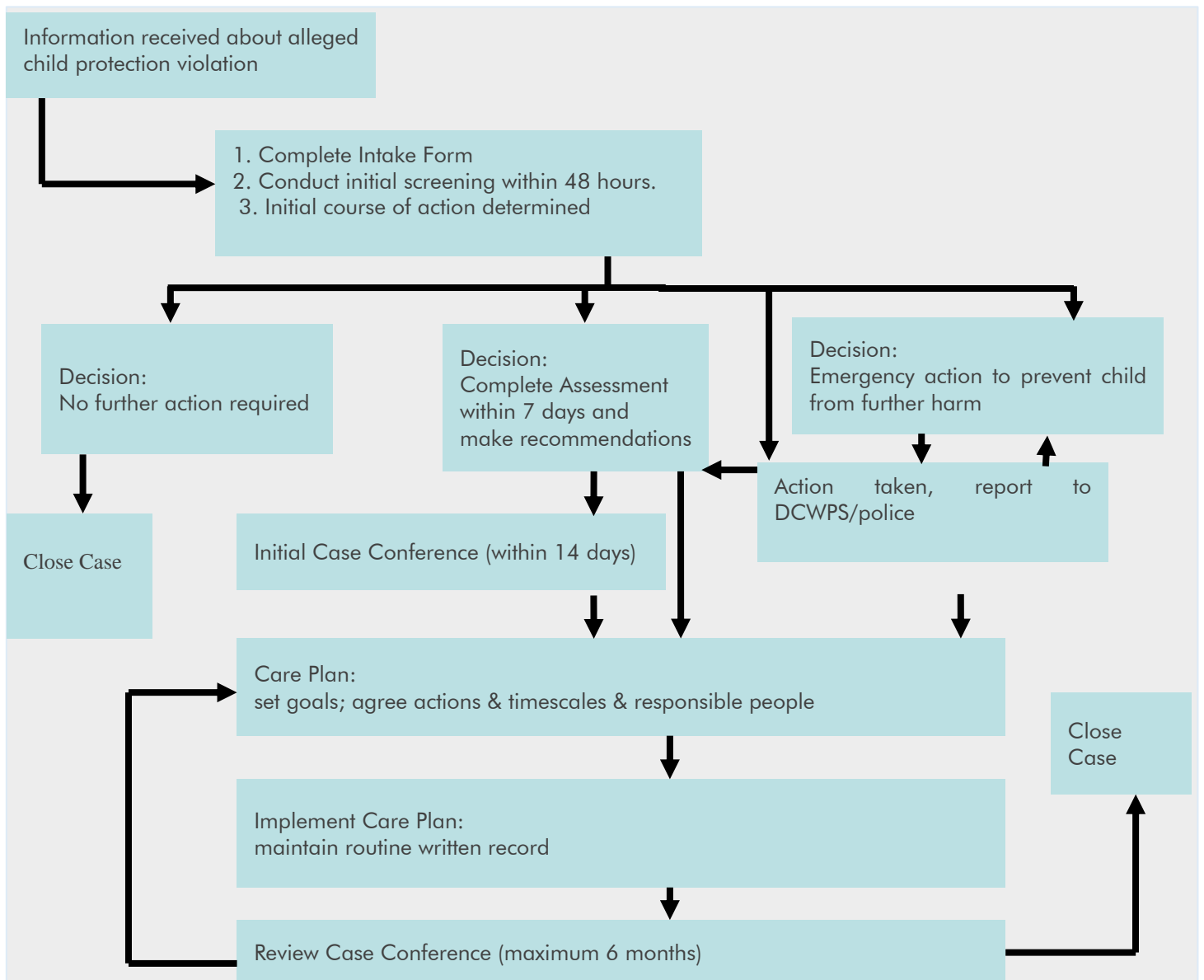


Figure 5. The Process of the NCMS

Section 1: Intake

The intake is the start of the process of caring for a child within the case management system. This step begins when someone alerts a CCW or any member of the CPC that there is a potential concern about a child within the community. The process can be initiated by a:

- professional, such as a teacher, doctor, nurse, pastor who has reason to believe that a child is vulnerable and not being protected or receiving care that they should;
- parent, guardian, other family member or friend who has reason to believe that the child is in need;
- CPC member who, as part of their function, identifies a vulnerable child;
- child him or herself.

Once a child is identified as vulnerable and potentially in need of services there is a step by step process that is initiated.

The person or agency receiving the initial alert of a concern has to obtain some basic information as soon as possible within the first 48 hours so that a decision can be made about what to do next. The information that is critical is:

- The nature of the specific concern
- How and why it has arisen
- Whether the concern involves abuse or neglect
- What the child's needs appear to be
- Whether there is any need for urgent action to protect the child or any other children in the household

The intake is the process of establishing basic information on a child and the concern that has been identified.

The **Intake and Allocation form** (Appendix 1A) is completed by the CCW, or the person who is doing the intake. The intake must be completed within 48 hours in order to determine what happens next.

The decision about what to do next after establishing the initial information may be one of three options.

- Emergency action is needed to protect the child
- There is not a need for emergency action, but a more detailed assessment is required to determine a child's needs.
- No further action is needed

Regardless of the option that is deemed most appropriate, it is essential that the child and family fully understand the decision being made and what to expect regarding next steps, including:

- what they need to do;
- what others will do; and
- by when.

1. If it is determined that **emergency action is needed**, whether due to a medical emergency, or any form of violence or potential conflict with the law, the person doing the intake takes specific action as follows:

- These cases are not handled at the community level and the child is immediately reported to the DCWPS, police, specifically the VFU, or providers of emergency medical treatment.
- After the DCWPSO, police or medical personnel responds by providing the requisite emergency treatment they will either assume the role of managing the case or refer the child to the appropriate person to do so;
- DCWPS or other case manager communicates back to the referring community worker regarding the emergency treatment and status of the case;
- At a time when deemed appropriate in the case, the DCWPS will refer the child back to the CCW so that support services can be provided. When referred back, aspects of the care plan that are being referred back to the community level should be spelled out by DCWPS, including specific objectives and timelines for implementation and case review;
- Additionally, the CCW should actively seek guidance from the DCWPSO regarding support services to offer to offer the child at this point.

2. If it is decided that **more information is required**, a full assessment should be completed within 7 days. Guidelines for completing the assessment are provided in Section 3 of this chapter.

Not all vulnerable children are in need of case management services. When the intake screening determines that a child is living in a supportive environment where basic needs are being met in as realistic way as possible, the decision may be that, while the

child is vulnerable, appropriate resources are already being accessed and **no further action is needed**. When this is the case, the Intake and Allocation form must be completed and the reason for this decision must be clearly stated. This form will be kept in a folder of intake forms completed but for which a case file is not opened.

Case categorization

The categorization is important for the purposes of determining the response required. All cases identified as having potential protection concerns should be referred to DCWPS immediately. Once they have been received at that level decisions will be made regarding the unique needs of each individual case and the department will respond accordingly. Responses include referral to other relevant government institutions; a child protection or family group conference; removal of the child to a place of safety in keeping with the provisions of the Children's Act (5:06); and/or coordination with CCWs and other relevant parties at the community level. All cases that are to be treated as urgent and reported as such include:

- Sexual abuse*
 - Physical abuse*
 - Abandonment/severe neglect*
 - Children living and working on the street
 - A need for adoption
 - Emergency food need
 - Emergency treatment need
-
- **Physical abuse*:** These are cases which may involve the child being hit with a weapon or an implement, being thrown, poisoned, burnt or scalded, drowned, suffocated or otherwise harmed and left with marks.
 - **Emotional abuse*:** These are cases in which a child is subjected to persistent emotional ill-treatment that can cause severe adverse effects on the child's emotional development. They may involve name calling and 'labelling' of the child as being worthless or unloved etc.; the imposition of developmentally inappropriate demands on the child, causing perpetual fear, insecurity and feelings of inferiority.
 - **Sexual abuse*–** These are cases in which a child is forced or enticed to engage in sexual activities, during the course of which the child may or may not be aware of what is happening to him or her. Activities can include but are not limited to physical contact, including penetrative (e.g. rape) or non-penetrative acts such as exposing them to pornographic material; or encouraging children to behave

in sexually inappropriate ways. It is important to note that children and young people are most commonly abused by those known to them, and less frequently by a stranger.

- **Neglect***- In these cases, the child's condition points to a constant lack of attention to basic physical and/or psychological needs, such as lack of food, shelter or basic consideration, which is likely to result in the serious impairment of the child's development. Cases in which a caregiver is oblivious or unresponsive to a child's basic emotional needs, or fails to act to prevent harm to the child also constitute neglect.
- **Children in Need:** These are cases involving children whose vulnerability is such that they are unlikely to achieve and maintain a satisfactory level of health or development, or whose development will be significantly impaired without the provision of services to assist them. The term 'health' is used here in its broadest sense as defined by the World Health Organisation.³⁸ "Children in need" can also refer to those children who are suffering or likely to suffer significant harm and need protection and safeguarding.

In addition to the cases that require immediate referral to the DCWPS, there are children identified as vulnerable, or as Children in Need who can be case managed at the community level. These are children who have a need for services in order to better provide for their wellbeing, but for whom the identified need is not urgent and will benefit from a full assessment. Examples of vulnerable children who would benefit from case management but for whom issues are not identified as urgent are non-emergency medical issues, psychosocial needs; or birth registration.

By analysing the initial information received on the child, the social/case worker or other stakeholder who has been notified of a concern about a child can make recommendations for action to be taken. If the decision is that the child does not have urgent needs that warrant immediate reporting and a full assessment is commenced, immediate referral should be made at any point if suggestions of abuse or other serious protection issue emerge during the course of the assessment.

³⁸WHO defines health as " ...a state of complete physical, mental and social wellbeing, not just the absence of disease or infirmity"

Removal of Children to Places of Safety

There are times when there is good reason to believe that it's not possible to keep the child safe in their home or with some other relative or close adult who is part of their normal social circle, that it is necessary to place them in designated place of safety. This should be done only when all efforts to keep them safe in their own environment, e.g. removing the perpetrator, have been futile. Further, the ethical principle of do no harm should always be maintained.

In order to remove a child, it must be determined that the risk of harm from the removal is not greater than the risk to the child should he or she remain in their living situation. When careful assessment makes it clear that there is a need to remove the child from their place of abode, such removal should be conducted according to Chapter 5:06, Section 14 of the Children's Act which stipulates that:

1. Any police officer, health officer, education officer or probation officer may remove a child or young person from any place to a place of safety:
 - a) if he is, in the opinion of that police officer health officer, education officer or probation officer, a child in need of care;or
 - b) if there are reasonable grounds for believing that an offence specified in the First Schedule is being or has been committed upon or in connection with that child or young person.
2. Unless it would be impracticable or detrimental to the best interests of the child or young person concerned, a police officer, probation officer, education officer or health officer shall place a child or young person in a place of safety in terms of subsection (1) within the family or community where the child or young person was raised.
3. A police officer, education officer or health officer who has removed a child or young person to, and any person who receives a child or young person in, a place of safety in terms of subsection (1) shall notify a probation officer for the area in which the place of safety is situated of such removal or reception as soon as possible and in any event within five days of such removal or reception.

Section 15 Paragraph 3 of the same stipulates that:

(3) Any police officer acting under a warrant issued in terms of subsection (1) or (2) may enter, by force if necessary, any house or other premises wherein the child or young person who is the subject of the warrant is suspected to be and may remove such child or young person from the place where he finds him to a place of safety.

Section 28 establishes that places of safety and remand houses may be established by the Minister for the reception of children and young persons in terms of this Act, and, in regards to registration of institutions.

Section 31 stipulates that:

- (1) Subject to subsection; and
- (2) no person shall receive any child or young person in an institution unless that institution has been registered in terms of this section in the name of that person or otherwise than in accordance with the conditions on which that institution has been so registered.

A child who has been placed in a place of safety needs to then be brought before the court as soon as possible, and not longer than 7 days from removal, for further determination (section 17).

Following removal of the child to a place of safety or if it is decided that more information is required a full assessment should be completed within 7 days.

When a parent is the suspected abuser³⁹

Consent


Social Worker can consent on behalf of the child in line with provisions of the Children's Act.

Safety

The court can issue a protection order and direct the suspected abuser to be away from the family.⁴⁰ In determining a response, the safety of other family members (e.g. mother, siblings etc.) should also be considered. Any police officer, health officer, education officer or probation officer may, as a last resort, remove a child or young

³⁹ This section is taken directly from the Protocol on the Multi-sectoral Management of Sexual Abuse and Violence in Zimbabwe, 2012

⁴⁰Part III of Domestic Violence and abuse Act [Chapter 5:16] as cited in the Protocol on Multi-Sectoral Management of Sexual Abuse and Violence in Zimbabwe, 2012



person from any place to a place of safety. In the event that the police officer, education officer or health officer removes the child in need to a place of safety, the probation officer must be notified immediately.⁴¹ It should be noted, however, that it is generally in the best interest of the child to support them to remain in their home, and remove the perpetrator.

⁴¹Section 14 (1) Children's Act [Chapter 5:06] notes that the Probation Officer is to be notified as soon as possible and at a maximum, within 5 days.

Section 3: Assessment

Following the intake a full assessment is carried out when there is reason to believe the child is vulnerable and potentially in need of support services. A full assessment may also be prompted by the DCWPS following emergency action to ensure a comprehensive understanding of the child and provision of appropriate services.

The assessment process should be completed within 7 days of the date of the intake or the date when referred back to the community by the DCWPS following protective action. A thorough assessment means getting information that paints an accurate picture of the child. It means gaining an understanding of the child's external world, e.g. how well his/her family or caregivers can provide a safe and nurturing environment; and internal world- their emotional and psychological experience. The assessment collects more information about the child protection problem and also gathers more information about the basic needs of the child. A comprehensive assessment should gather information from as many people as possible in addition to the child and family, such as teachers, community leaders and other agencies (education, health, etc.) and neighbours. A complete assessment looks at all parts of a child:

Family and current living situation of the child, including financial status of the household

- Physical status
- Psychological status
- Social functioning
- Cognitive/educational functioning
- Significant losses and changes in the child's life
- Strengths of the child and family
- Problems that need addressing in any of the above areas



Figure 5: A Systemic Approach to Assessment⁴²

In gaining the information to complete the picture of the child, understanding will develop regarding any specific protection concerns. It will also identify other areas of concern or vulnerabilities affecting the child that may or may not be directly related to the protection concern stated in the intake. Finally, the information will help prioritize which issues or needs are of most concern and the most urgent to address. This understanding will provide the foundation for the development of the care plan.

The Assessment and Care Planform (Appendix 1B) provides guidance in carrying out a comprehensive assessment. As the assessment is done, the form is completed and becomes a part of the permanent file. It will also provide critical information to determine whether a case conference is needed. In the event a conference is indicated, the information included on the assessment form will be discussed at the case conference.

⁴² Assessing Children in Need and Their Families: Practice Guidance, Social Care Group, Department of Health, London, 2000

1. **Assessment Guidelines:**

The assessment should be completed within 7 days. Child's name and date of birth: this information should correspond to that collected on the **Intake and Allocation** Form.

- i. Name, occupation and contact details of person completing the assessment: it is important to make sure that a suitably qualified person completes the assessment. This should be someone who has received the appropriate training in Child Protection and Case Management. It is likely that this will be a member of the CPC, the DCWPS or a community member affiliated with a local NGO.
- ii. Date of referral and reason for referral: this will help to make sure that the assessment is completed within the required timescales and that the investigation refers to the initial concerns which were raised about the child. This section should align with the statements on the Intake and Allocation form.
- iii. Dates of visits to the child's family home: the person completing the assessment will need to speak to the child's parents, any other significant relatives or neighbours and the child. They will also need to see the conditions in which they are living in order to make a full assessment of any 'survival' concerns. Additionally, a brief statement about the information discussed, or the general focus of the visit should be noted (see example of completed form, Appendix 1B). More complete description of the information gained from visits will be included in the subsequent descriptive boxes on the form.
- iv. Dates of significant contacts with any other professionals: it is likely that other people will be able to provide information to help develop a complete picture of the child's life e.g. if the child is school age the teacher may have noticed changes in behaviour or the police may have been involved with the family previously. Again, a brief statement of the focus of the visit or the information gained should be noted.
- v. Family: Parents and Caregivers: A description of the child's primary attachments is very important in understanding a child's experience. This section should provide information on important family members the child lives with, significant family members the child has lost (due to death or abandonment), and the people the child currently lives with. If a child has been orphaned, it is important to note how recent the loss(s) are, as these are likely to have direct bearing on the emotional state and behaviour of the child.
- vi. Survival: in the context of the environment, is the family able to provide adequate food and shelter for the child? Are they less well off than the majority of their neighbours? Do they receive any assistance from government or NGOs? It is

important to assess the family based on the standards prevailing in their community at the current time. No child should be removed from the family home solely for reasons of poverty.

- vii. General health: does the family understand how to meet the child's needs in the area of health? If immunizations are available have they taken advantage of the opportunity? Does the family need any assistance in helping the child receive adequate health care? Does the child exhibit any signs of unattended health care problems?
- viii. Development: it is important to assess whether the child is developing appropriately for his age and if not, to try and identify the reasons why. Is he receiving enough stimulation? Is he with other people for a good part of the day? Are there prolonged problems with adequate nutrition or any health problems which might cause developmental delays? If the child is school age, does he or she present as someone who has the ability to think or understand at the level of other children of the same age?
- ix. Behaviour: by observing the child in different situations and asking for information from people who are close to him you can find out if the child behaves appropriately for his age. You can also find out if there have been significant changes in his behaviour which can be associated with specific events, e.g. a child who begins to be fearful, have nightmares and becomes withdrawn since her uncle returned to live in the family home. This may indicate concerns about the nature of their relationship and may be one indicator for sexual abuse. Or, a child who is acting out in ways that are not characteristic is likely indicating that they are troubled by something happening to them or around them. An effort should be made to understand all changes in behaviour, or inappropriate behaviour, as behaviour is the primary way that children have of communicating their experience.
- x. Social history: it is important to know as much about the environment in which a child lives and the people he is meeting as well as knowing if there have been any significant changes. What are the child's relationships with people outside the family: friends, teachers, or other significant adults? How are his relationships with his peers? Have there been any recent changes in any of these relationships? What are the child's interests? Does the child engage in age appropriate activities? What are the strengths the child exhibits?
- xi. Education: How does the child perform in school? If the child is not achieving his educational goals then it is important to find out why. Is he attending school regularly? Is he finishing his homework? Are there recent changes in the child's academic performance?

- xii. Child's comment on the assessment: in order to build relationships of trust and confidence it is important that the child understands what is happening. The CCW, social worker, or other person doing the assessment, also needs to take into consideration the child's wishes in relation to any decisions that are being made. Especially in child protection cases, children often feel more powerless than usual; including them as much as possible in the decisions about the things which affect their lives will help in making appropriate decisions.

Children above the age of 12 should complete **"My Life Now: Ask the Expert,"** (Appendix IIIA) as part of the assessment process. This exercise will provide important information about how the child sees him or herself and the world around them. It can also assist the child in thinking about themselves which may make it easier for them to describe their experiences and engage in the discussion about their assessment and needs. This exercise is carried out as follows:

- The CCW gives the child a copy of "My Life Now: Ask the Expert" to fill out on their own. For each topic, the child is instructed to circle the number, ranging from 1 (least) – 5 (most), next to the sentence that most closely describes their thoughts and feelings.
- When completed, the CCW adds up the numbers selected for each of the topics, resulting in one final numerical score that indicates the child's sense of well-being.
- This score is recorded at the bottom of the page.

It is recommended that this exercise be completed intermittently over time, such as when case reviews are performed. The score on a new one can be compared to those previously administered, thus providing information of the effectiveness, or lack thereof, of the care plan as well as giving information on the present state of the child.

- xiii. Conclusions: once all the information has been obtained from as many sources as possible the case worker will be able to draw a conclusion about whether there is a serious child protection concern, what that concern is, what evidence there is to support it and how it is affecting the child. Sometimes when a child is being abused their own behavior can come under scrutiny. It is important to remember that the child is the victim and to record all information sensitively.
- xiv. What needs to change so that the case can be closed? This is the opportunity to describe what the child's life will be like when there is no longer a child protection concern e.g. Jose does not come to school with cuts and bruises, Jose's father is able to look after the family and no longer insists his son should be working. The success of any intervention can be measured against this best case outcome.

Stating the goals of the case management care plan in this way provides objective, observable measures to determine whether the desired changes are occurring over time.

- xv. Sometimes a child's situation contains multiple challenges, and is particularly complex in terms of thinking through how to address the issues identified. In these situations it is generally beneficial to have a meeting that brings together all involved stakeholders to develop a shared understanding of the problems at hand and the ways to best address these problems. When this is the situation, a **case conference** and/or a **family conference** is called in order to complete the assessment process. Conducting a case conference or a family conference is described in detail in Section 4, of this chapter.
- xvi. If, in the course of the assessment, it is determined that a case conference is needed, it is documented on the Assessment and Care Plan form.

2. Care Planning

After developing an understanding of who the child is, and his or her specific needs based on the information gained from the assessment, the plan of care must be developed. The care plan details:

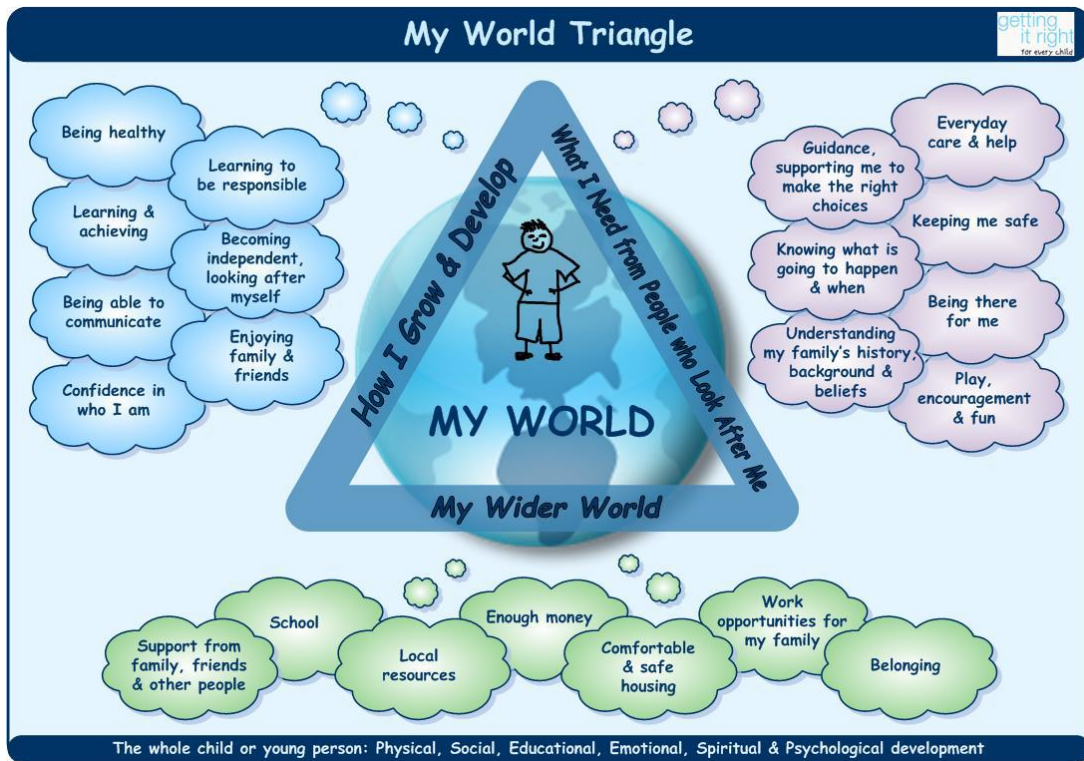
- the needs that have been identified;
- the strategies for addressing the identified needs;
- what will be done to address these needs;
- specifically who is responsible for doing what and by when; and
- how the child will be protected from further harm during this process.

A good care plan must:

- focus on safety and developmental outcomes for the child, even though services may be provided to a number of family members as part of the plan;
- be designed in collaboration with the child and relevant family members;
- address the child's immediate and longer-term needs, with specific, measurable, and achievable changes, along with specific timelines for each.
- identify all resources, individuals and organizations who will play a role in addressing needs;
- clearly identify who will be responsible for what and by when;
- articulate procedures for monitoring and review, so that progress or lack thereof can be assessed along the way

- be stated in clearly observable terms, or statements of necessary changes, so that it is possible to determine when the goals are achieved and a case can be closed.

Figure 6: My World Triangle⁴³ depicts the areas that should be kept in mind when devising a care plan that supports the needs and development of a child.



In developing the care plan the service mapping described in chapter 1, section 4, is drawn upon. The strength of the case management approach is the combining of all identified needs, with any and all resources available to the child in order to meet those needs. Needs can be addressed by drawing on the formal as well as the informal resources and supports.

It is vital that the child is involved in the development of the care plan to the extent that their developmental level allows, so that they fully understand the assistance that can be provided. This will help them to manage their expectations of the interventions, and enable them to contribute to the planning, implementing and monitoring process. If the

⁴³ Getting it Right for Every Child, <http://www.scotland.gov.uk/gettingitright>, Scottish Government, 2008.

child is living with a family member or other caregiver, that person must also be involved in the development and implementation of the plan.

On the Assessment and Care Plan form.

1. Objectives of the care plan:

What are the main goals for the child e.g. to be safe, to live without being beaten or abused, to return home to his or her birth family; to live with relatives; to improve educational opportunities; improved health care; overcoming trauma etc. These objectives are statements of what needs to change in the child's life in order for needs to be adequately addressed, or the desired endpoint of the work. Objectives must be:

- based on the best interest of the child;
- developed in collaboration with the child and/or family, and relevant stakeholders;
- be stated in observable terms such as changes in behaviour or functioning of the child, their family, or their environment, so that it is possible to determine when they have been met.

2. Action Plan:

This is where the specific actions which need to be taken will be recorded. These can be one-time actions that need to be done by a certain date, i.e. take child for health check at hospital; or they can be actions that happen more than once at regular intervals, i.e. meet with parents every Monday to talk about how they can manage the child's behaviour more effectively. Although there may be more than one person with responsibility for making things happen the DCWPSO is ultimately responsible for making sure that these actions are carried out.

The action plan details:

- the steps that will be taken to address the needs of the child;
- the resources that will be accessed in order to meet these needs;
- the needs of the household as they impact the child;
- the role of family members in addressing the identified needs;
- the formal and informal resources that will be drawn upon;
- psychosocial support that the CCW or other involved people can offer.

The action plan should address both short term and long term needs. For every action described in the plan, the corresponding box on the form that identifies the required frequency of the action must be filled in, e.g. once, weekly, monthly, whatever is appropriate for the specific activity. Also to be completed are the boxes identifying who is responsible for doing or ensuring that the action is carried out. Finally, it should be noted the date by which the activity will be done, or, if it is ongoing it can be stated as such.

3. **Signatures:** Upon completion of the Care Plan, it is extremely important that each involved member signs the form. The care plan is the 'contract,' or explicit agreement between the child, family, the case management team and all other involved parties. This signature on the care plan is the statement of each identified person that they understand and agree to the plan that has been developed and to their role in the plan. Their signature is their explicit statement that they agree to carry out their stated responsibilities. It is the statement of their specific commitment to the child.
4. **Date of next review:** the plan may be short term, something which can be reviewed in a matter of weeks or long term, but not more than 6 months.

Section 3: Implementation and monitoring:

As stated above, the action plan sets out the guidelines for the activities that will be carried out and the parameters for monitoring these activities. In many cases, in order to address the needs identified on the care plan, links with additional providers will need to be made. Successful linkages are key to the success of the NCMS.

1. Inter-agency referral

All referrals must be directed towards the needs of the child or family, and made with their consent. Additionally, all referrals must be documented in the case file on the **Record of Significant Events and Contacts** form (Appendix C).

Referrals may be made at any stage of the case management process, but most often they are required at two points:

- **At identification:** Any person who comes into contact with a child and/or family in need of assistance should know how to make a referral to a child protection agency.
- During the **implementation of the care plan** developed for the individual child

Best Practice for Referrals

- **Accompany** the child / family to the service
- Be familiar with the services offered and staff providing them.
- Caseworkers **maintain overall responsibility to follow up** with the child and service providers to ensure needs are met.

Developing Referral Mechanisms

- Children's rights and the case management principles underpin best practice for referrals
- Inter-sector and inter-agency collaboration make referral possible and effective

- The establishment of a referral mechanism between agencies and/or government departments should be supported by a documented referral pathway that is updated
- Focal points for referrals should be established within each agency
- If particular services a child requirements are not available, agencies and governments should work together to try to fill these gaps.

No one organisation can provide all services a child may need. Different organizations will offer various specialty services or expertise, may serve as second opinions, or offer other types of support. They also may be able to offer other views or feedback on the management of various issues with a child. All communities, as part of the service mapping exercise (should compile a listing of programmes and services in their communities that can serve as a resource directory. This directory of services should include relevant district and national level services as well as those that are local.

A referral to an additional provider should be made when a need identified on the care plan can be better served by someone other than the providers already involved in the care of the child. The referral should be made for a clear reason and to an organization that provides the services needed.

Referrals can be made by:

- The child
- A family member
- The CCW
- Any service provider involved in the care plan

Referrals can be made

- In person
- By phone
- Email or any other written communication

All organizations or departments should have a form for referrals. A referral form (Appendix ID) should include:

- Either a tear off slip, duplicate copies, or some other mechanism that enables both the referrer and the recipient of the referral to maintain a version of the original referral;
- A statement of the problem or need that needs addressing;
- A time frame indicating the urgency of the need;

- A request for confirmation that the referral was received and can be accommodated;
- Contact information of the referring organization;
- A request for follow-up after the child is seen regarding the care being provided or plan for moving forward.

It is always important that referrals are coordinated with and documented on the care plan so that at all times it is possible to have a clear picture of the players involved in the care, and who holds responsibility for what.

Referral follow-up and feedback

When a referral is made to a provider, it is essential that there is follow-up and feedback. It is the responsibility of both the:

- referring person to follow up in order to be sure that the provider being referred to acts on the referral, e.g. meets with the child or family.
- provider receiving the referral not only to act on the referral, but to give feedback to the referrer 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.

2. Supporting the Child

In addition to tangible resources to meet varying needs, vulnerable children and families who are overly burdened or struggling to cope often benefit from psychosocial support. The CCW can play an important role in supporting the child and family. Even when not able to solve some of the problems that exist due to lack of tangible resources, it can make a big difference for an interested and caring adult to:

- maintain contact,
- be available to listen to the child, and
- make an effort to understand the experiences of the child; their successes and their challenges.

Especially for children who have been abused and have a difficult time trusting people, the relationship that is sustained over time can have a tremendous impact on the child's

emotional development and self-esteem. Additionally, intermittent home visits will provide the CCW with the opportunity to observe dynamics within the household and identify areas of stress that need support in order to maximise the support the child receives in the home. Specifically, home visits and other meetings with the child or family enable the CCW to:

- provide support and guidance to the child;
- provide support and guidance to the caregiver, when needed, on how to develop and maintain a healthy and protective relationship;
- assess the child's perspective and opinions about the situation;
- respond to specific requests and suggestions of the child in regards to their care;
- update the child and caregiver on progress made towards long-term care and protection solutions;
- monitor for and mitigate the risk of abuse, neglect or exploitation of the child;
- ensure that the service providers to whom the child has been referred are providing assistance in a safe, collaborative environment.

Regular contact with the child provides the opportunity to monitor the effectiveness of the care plan as time goes along. It will also help the CCW to ensure that the child and family are accessing services and community resources in keeping with those identified in the care plan.

Working with children who have been abused:

Children who have been abused need some special consideration. The most important aspect of the CCW's work when involved in case management of an abused child or adolescent is that of developing a trusting and supportive relationship with her or him.⁴⁴ It is important for all people working with a child who has been abused to understand:

- that the child is likely to feel mistrust. They have learned that people will hurt them, including people who they love and depend on;
- that the child is likely to feel ashamed. Regardless of the objective situation, children's developmental capacity generally leaves them feeling responsible for the abuse in some ways. They also interpret not being treated well as *not*

⁴⁴ Protocol on the Multi-sectoral Management of Sexual Abuse and Violence in Zimbabwe, 2012

deserving to be treated well. Abuse has a significant negative impact on a child's self-esteem;

- how to manage immediate safety issues of children experiencing any kind of violence;
- the importance of using child-sensitive verbal and non-verbal communication skills and strategies;
- child development, both intellectual and emotional, and the interface between a child's level of understanding and their experience of abuse. The child's level of development will also guide the best ways to interact with the child in order to build trust;
- that children communicate their experiences through their behaviour. Acting out, angry or withdrawn behaviour is the child's way to cope with their overwhelming and confusing feelings following abuse. Responding to a child in ways that lets them know you are trying to understand them is important. It is also important to not get drawn into negative behaviour and to react to the child with the same emotions they are expressing, e.g., anger, or engaging in a power struggle;
- how to incorporate the family into the case management care plan;
- how to include the child in the care planning, but avoid making them feel like they are responsible for all the decision making. Children need to feel that others will step in, take care of them and protect them. Adults need to be clear with the child about what they themselves think should be done; and what they themselves will do, and that it will be done with the child's understanding and consent.

Additional information on working with children who have experienced violence and abuse, including the first contact with a child can be found in the Protocol on Multi-Sectoral Management of Sexual Abuse and Violence in Zimbabwe.⁴⁵

Case Review

While care plans must be formally reviewed at least every six months, the frequency of the review for each individual child should be determined by the needs of the child and the care plan. It is not necessary to wait for a set amount of time to alter the approaches in the care plan if it's observed that new needs have arisen, situations aren't seeming to change at all, or alternatively, if problems appear to have been solved. It is important to note that high risk cases must be regularly reviewed, at least monthly. If there is any

⁴⁵Protocol on the Multi-sectoral Management of Sexual Abuse and Violence in Zimbabwe, 2012. This protocol can be obtained from the Judicial Services Commission.

suggestion at all that the safety of a child is questionable, or their development compromised in any way, frequent follow-up, e.g. weekly, is very important.

Regardless of when they are carried out, all case reviews must be documented on the Case Reviewform (Appendix IE.)

Cases that have been open for long periods should be reviewed to ensure that needs are being addressed, that all partner organizations are active and carrying out their responsibility as stated on the care plan, and can justify the case remaining open.

Conducting a case review

Like all other parts of the case management system, there is a step by step approach to the case review. Again, this process should be carried out at least once every 6 months, and sooner if there are major changes pertaining to the child and their situation. The steps to be taken are:

1. Go back to the first assessment and care plan. Read through the description of the child as recorded on the assessment; does this still describe the child and his or her situation at present? Are there any observable changes, either progress or setbacks?
2. Review the action plan. Have the actions identified been carried out? Have the timelines been met? Have the identified parties carried out their agreed upon responsibilities? Have the expected outcomes identified with each action been achieved?
3. Review the significant events and contacts log. What information can be gained from this regarding the development of the child and the work of the case management system?
4. Go through each of these steps with the child and parent or caregiver. Providing that the child is old enough to have engaged in the development of the initial care plan, read through the assessment with them. Does he or she think this still an accurate description? Are there any changes, or things the child would now describe differently? If the child is very young, these questions should be directed to the caregiver.
5. Review the initial action plan with the child and parent or caregiver. Again discuss changes. Does the child think that agreed upon activities have been carried out? Does the parent? Have they achieved the expected outcome as perceived by the child and parent or caregiver?

6. Are there any new problems or needs that have arisen since the last care plan was written?
7. This is a good time to have the child again fill out "My life Now: Ask the Expert," if developmentally appropriate. After completion, discuss changes with the child, or reasons they think that nothing has changed if this is the case.
8. Based the thought given to and discussion of the previous steps, write out new care plan. Actions that have been completed, or for which the desired outcome has been achieved no longer need to be included. New needs identified must be included with associated items filled out: action, how often/when, person responsible, expected outcome. Actions that are ongoing should be included on the new care plan.
9. **New** actions, or **changes** made to formerly identified needs that involve a person or organization that is not present for the review must be discussed directly with the person who is identified as responsible for carrying out the action.
10. This revised care plan must be signed by the CCW or case management person who is completing the review, the child, the parent or caregiver, and any person identified as responsible for a new action. If the person identified as responsible is not easily reachable in person, but has discussed and agreed to their responsibility over the phone, this can be noted where the signature should otherwise be.
11. **Date all care plans.** This is particularly important for cases that stay open for long periods in order to easily see what the current situation of the child is, as well as to track intervention and progress over time. All reviews and alterations to care plans when complete, if not before, should be discussed with the LCCW.

Attach the new care plan to the end of the existing compilation of previously completed forms. Prior to attaching, put a vertical line through all unused boxes on the **Record of Significant Events and Contacts** (Appendix IC) form that details events up until the case review. Secure a new **Record of Significant Events and Contacts** after the new care plan. This will allow the reader of a record to easily follow the sequence of evaluations and interventions with the child.

Case Transfer

There are times when a child's needs are best served by transferring the case to another office or organization. Examples of times when a transfer is warranted include a change in the child's circumstances or primary needs, or a geographical move to a different location. Changes in circumstances include increases in severity of the threat of harm, or significant decrease in threats to safety. Regardless, the reasons for transfer should be:

- a) discussed and agreed upon between the case management team, the child and the family;
- b) clearly documented in the case file; and
- c) coordinated between the lead organization terminating care and the one picking up the case.

When transferring a case is being considered, the following questions should be asked:

- Has there been discussion with child and or family, and are they in agreement with the decision?
- Is the child safe now, or will the transfer increase the child's safety?
- Will the transfer serve the purpose of meeting the child's needs in the most effective manner?
- Is the action in the 'best interest of the child'?
- Does the child/family have the name and contact details of the organization or agency that his or her care is being transferred to, and if possible a specific contact person?
- Have all possible efforts been made to assist the child?

Case Closure

The goal of case management is to meet the needs of a child to the degree where there is no longer a need for case management services, at which point a case will be closed. The **Case Closure** form (Appendix F) is to be completed and placed in the case file. Questions that should be considered when thinking of closing a case include:

- Has there been discussion with child and or family, and are they in agreement with the decision?

- Is the child safe now?
- Have the goal(s) of the care plan been met?
- Has the child been made aware of the resources that are available to them if another child protection issue or need arises?
- Has the case worker acted in the 'best interest of the child'?
- Have all possible efforts been made to assist the child?
- What can we learn from our intervention with this child and/or family?

All decisions to close a case must be made in collaboration with the child and family. Additionally, no case can be closed without consultation and authorization by the case manager's supervisor.

While the aimed for reason to close a case is that needs have been met, in reality, there are other reasons that a case will be closed. These include:

- The child dies
- **The child moves to another location (see case transfer).** In this event, discussion should take place with the child and/or family regarding transferring their records to another agency in another location.

Cautions about case closure:

There are times when a child or a caregiver wants to end services despite needs identified in the care plan not being fully met. While doing so may seem compelling for various reasons, these are often the cases that warrant the closest attention. Wanting to prematurely close a file may be due to the following reasons:

- **The client no longer wants the services** – Sometime a child is not satisfied, becomes frustrated, or are highly ambivalent about receiving services. If a child wants to end services before it is agreed that needs are met, it is important to try to learn more.
 - i. Examine the reasons with the child for the wish to end before doing so.
 - ii. Sometimes the wish to end is a response to difficulties that could be addressed in better ways than ending services. Assume first, if there are outstanding issues that have not yet been addressed or completed, that the child's wish to withdraw is their way of communicating some sort of hurt, dissatisfaction or need.
 - iii. Determine whether there are factors that can be addressed that will better engage the child, e.g., from the child's perspective was trust violated in some way over the course of the case management work? How can things

be handled differently in the future? Or, is the child getting any kind of pressure from caregivers to end?

- **You cannot find the child.** On occasion, a child disappears in order to indicate they no longer want services or that they are being pressured to end services. Rather than close the case, these cases should be considered high priority. All efforts to find the child must be made, including talking with family members, teachers, health care workers and other community members who know the child and family. It may also require contacting extended family members who live at a distance. Even if all efforts fail to locate the child, these efforts should be repeated at least every 6 months. Until satisfactory information is gained, the file must be kept open until after the child's eighteenth birthday.

Section 4: Facilitating the Case Management Process

Case conference

Conducting the case conference, like all other aspects of assessment and care planning, follows a step-by-step approach.

1. Begin the conference with introductions that include name and relationship to the child, e.g. social worker, teacher, parent. If an attendee is not directly involved with the child, they should briefly state the reason they are attending.
2. Stress the importance of confidentiality. No information discussed at the case conference will be shared with anyone outside without explicit agreement on what information will be shared, with whom specifically, and for what purpose. For example, if it is agreed upon that the child will be referred another agency or community resource for the purpose of addressing specific needs, it must be made clear what will be shared and how this will be done.
3. The case manager should state the reason that the conference has been called, briefly describing the concerns that have been identified over the course of the assessment. Following this, all other participants should be invited to add any issues or concerns that have not already been stated.
4. Discussion should be invited regarding management of all problems or concerns that have been raised. Discussion should stay problem oriented. This means that for each problem that has been identified, there should be discussion on what can be done to address the issue. What resources are available, how can they be accessed, who can take responsibility for accessing them, and so on. Also important to discuss are potential obstacles that are in the way of rectifying the problem. For every obstacle, how can it be addressed? Some obstacles are not within people's power to change, e.g. overarching poverty or lack of resources in the larger system. For these, how can they best be coped with? Are there supports that could be helpful?
5. A summary of what was discussed should be given by the person coordinating the conference. This summary is a statement of each problem and the actions that have been agreed upon to address the problem. This summary is

documented on the **Assessment and Care Plan** form (Appendix IB), in the box titled, "Agreements of the Case Conference."

6. Following or along with the agreements on actions to be taken, exactly who will do what and by when, must be agreed upon and documented. Each person, including all case management personnel and family members/guardians must clearly know their responsibility in moving forward for the purpose of improving the life of the child.
7. Finally, the **date for the first/next review conference** should be set, and the circumstances that might necessitate a case conference before this date defined. The Review Case Conference:

- looks again at the Care Plan, identifying the activities and approaches that are effective and achieving the desired result, those that are not doing so, and alterations in the interventions that should be put into place;
- evaluates the current situation and functioning of the child to determine whether new problems have developed or come to light that need to be addressed;
- makes any necessary changes to the Care Plan based on the discussion;
- The Review Case Conference may also result in the decision to close a case if it is considered that the needs of the child have been met.

A review Case Conference can be held at any time but at least every six months until the case is closed. Once closed, a file may be re-opened if further problems arise and there is indication that the child would again benefit from case management.

Family conference

Sometimes, when issues in a family system are complex, or there are divergent views about a child's needs and care among key family members, it can be very helpful to hold a family conference. It should be convened at times when it seems that difficulties in family communication, understanding or views are interfering with the care being provided to the child.

The goals of a family conference are to:

- facilitate communication between family members;
- support the family in identifying their own strategies for addressing problems; and
- unite the family around agreed upon approaches.

The family conference:

- Can be initiated by any member of the case management team or a family member;
- Is always geared toward and focused on the best interest of the child;
- Is facilitated by a care worker with the focus on family communication and empowerment;
- Invites the views of different family members in regards to both problems and solutions;
- Places the family at the center of the strategizing and decision making for a child;
- Includes the child whenever developmentally appropriate, though oftentimes with an identified advocate, unless there is a compelling reason to have discussion about a child without him or her present;
- Should end with an articulated agreement and/or understanding of strategies for moving forward.

The role of the facilitator in a family conference is to:

- Ensure that each participating family member has the opportunity to have their views heard;
- Encourage active listening between family members;
- Support the various perspectives articulated;
- Keep the discussion focused on the needs of the child;
- Encourage problem solving amongst family members;
- Summarize ideas and strategies identified by family members;
- Conclude the meeting by articulating the agreed upon plan for moving forward, including what he or she has heard from the different family members regarding who is committing to do what;
- Communicate the family's plan to other relevant stakeholders verbally and via documentation in the case file.

Section 5: Special Consideration for Marginalized Populations

While case management is designed for all children in need of care, attentiveness to the specific needs of marginalised groups is essential. This is informed by the reality that in programming there is always the risk of inadvertently excluding certain groups due to lack of awareness. While the case management approach is the same for all, this section highlights specific issues important to consider when working with several commonly marginalized groups: children living on the streets, children with disabilities and children in contact with the law.

1. Children Living and Working on The Streets

Children living and working on the streets are a hard to reach population and yet prone to multiple threats to their wellbeing. It therefore becomes important to have a clear understanding of the needs and procedures to follow when working with these children. The information included this section provides guidelines for case management with this group of children.

Children working and living on the streets has been a growing problem in Zimbabwe. By 2004 there were an estimated 5 000 in Harare alone.⁴⁶ Given the numbers of the children, the challenges and vulnerability of being on the streets such as drug abuse, sexual abuse, hunger and lack of shelter, it is essential to extend child protection services to these children through the use of good case management. Case management for children living on the streets aims at the:

- removal of the children from the streets;
- reunification with their families/ extended family/community/foster care;
- post reunification support to the reunified child and the family to prevent relapse; and
- as a last option of care, placement of the children into institutions.

⁴⁶ Harare Task Force on Children Living and/or Working on the Street, Zimbabwe National Council for the Welfare of Children, 2004

Removal of children from the Streets

The removal of children from the streets is carried out as a joint operation with the police and the DCWPS. The removal of a child is done either voluntarily on the part of the child or by force. If forceful removal is required, it should be done in a child friendly manner. It is a mandatory requirement of the DCWPS to be present during the removal in order to guarantee child sensitivity in the process.

Specific Functions of the DCWPS

Child friendly rounding up of children from the streets:

- Temporary placement in places of safety and opening of case files following the guidelines of the case management system
- Reunifying the children with families
- Post reunification support
- Linking the reunified children with Village CPCs and the CCWs.

Specific Functions of the Police

The police have a zero tolerance policy regarding the presence of children living and working on the streets. This is largely motivated by the need to curb criminal activities on the streets. In the continuum of care for these children, the police have the mandate to remove the children from the streets in a child friendly manner. To do so entails that the police are made aware of the requirements of DCWPS to protect and safeguard the children. The presence of the DCWPS officers during the operation also means that there will be a child protection cadre on the ground to provide hands on support and technical support to ensure that children are not harmed in the process.

Specific Functions of the Case Care Workers

Case management for children living on the streets aims at the reunification of the children with their families. Post reunification support has been noted to be key in ensuring that the children do not go back to the streets. The support aims at addressing the issues that might have contributed to the children going to the streets in the first place. Once the DCWPS has completed the reunification, a referral to the community

support structures in order to support the child and the family is critical. With this goal in mind, the specific functions of the CCWs are to;

- provide psychosocial support to reunified children;
- ensure that reunified children are linked to services;
- provide family education and support in order to change dynamics that may encourage relapse;
- provide constant monitoring and ongoing support to the reunification process.

2. Children with Disabilities

Children living with disabilities face multiple challenges that make it critical to deliberately think of how best to cater for them. Many studies have noted the ways in which children living with disabilities face exclusion from education, cultural activities, festivals, sports, and social events. Additionally, they are especially vulnerable to poverty, physical and sexual violence. UNESCO studies have determined that only 1-2 % of children with disabilities in developing countries receive an education.⁴⁷

According to the United Nations Convention on the Rights of People with Disabilities (UNCRPD) “persons with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”⁴⁸ In this regard, it is important to fully recognize that the potential for the exclusion and violation of the rights of children living with disabilities is very high. Case Management for children with disabilities has to be informed by the UN Standard Guidelines on the Equalization of Opportunities which are,⁴⁹

Rule 1: Awareness Raising – there should be planned activities to raise the awareness of communities on the need to understand the concerns for children with disabilities.

Rule 2: Medical Care – the health needs of children with disabilities should be met and medical care should be made accessible to children living with disabilities,

⁴⁷JF Kapnek Trust, Zvimba District Disability Survey. National Programme for children living with disabilities. Rolling out Community Based Programs, 2012.

⁴⁸ United Nations Convention on the Rights of People with Disabilities, 2006

⁴⁹ UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities, 1982

Rule 3: Rehabilitation – physical rehabilitation services should be availed to children with disabilities. Early referrals should be encouraged given how these can result in better outcomes for children receiving therapy.

Rule 4: Support Services – in consultation with the children, parents and experts, appropriate and meaningful support services should be made available to children with disabilities.

Special Considerations for case management of children with disabilities

Given the multiple risks associated with disabilities, due to both physical and social factors, case management plays a particularly important role in the provision of care to this population. Specifically, CCWs:

- work in conjunction with Village Health Workers (VHW's) aiming at the community identification of children with disabilities;
- need to encourage families to take children with disabilities to health institutions for early management of disabilities;
- provide continued, critical support to the child and family through the case management framework.

Additionally, for children of school going age, schools psychological services should be sought and assessments provided to ensure appropriate school placements.

Finally, the reality that violence and abuse is high among children with disabilities should always be borne in mind. Care workers need to keep a particularly sensitive eye on this issue when working with children with disabilities.

3. Children in Contact With the Law

Children in contact with the law are a group of children at high risk of being harshly judged and not being considered for protection, rehabilitation and nurturing due to their anti-social behaviour. It is important, however, to consider the underlying, non-conductive socioeconomic factors in the child's upbringing that likely contribute to the manifestation of these behaviours.

In line with the principles of case management, children in contact with the law need to be viewed as children in need of support. This means that all the case management procedures need to be carried out with the intent of removing the problematic factors affecting the behaviour of the child and assisting them in learning socially acceptable ways of behaving and expressing themselves.

Tiers of case management of children in contact with the law.

The DCWPS Level

When children are in contact with the law, there are statutory functions for probation officers that cannot be substituted by case care workers. All cases of children in contact with the law should be referred to the DCWPS and handled in line with the required procedures. For case management, however, it is crucial when working with these children, that the child is approached with an open mind. A thorough assessment to establish the causes of the child's behaviour needs to be carried out. Support to the child should be unconditional. Succeeding at this may require the CCW and other involved parties to be aware of any negative judgments they are feeling towards the child or family, and find ways to manage these feelings so that they are not imposed on the child.

Community Level

While children in contact with the law are referred to the DCWPS, there is need for the DCWPS to always refer the children back to the CCWs for continued ongoing support. As part of CPCs, case care workers need to address issues of stigma and discrimination of children who might have been in contact with the law. Case management for children who have committed offences within their communities need to take a family and community strengthening approach whereby the children are fully reintegrated into their communities and have full support available to them.

Children who commit offences are often stigmatized and perceived negatively, thus undermining capacity for the provision of services to this group of children. Case management has to be fully guided by the principles of supporting all children in need of support, including children in contact with the law.

Chapter 4: Documentation and Record Keeping



Documentation of care is a critical part of an effective case management system. Regardless of the quality of individual services to a child, without good documentation, comprehensive and coordinated care cannot take place. Documentation is important for several primary reasons. Good documentation:

- is necessary to enable all involved service providers to follow the care of a child over time, understand what different stakeholders are doing so that services are neither omitted or duplicated, and provides a way to assess the progress made, or lack thereof;
- enables a new provider to step in and either pick up where someone else has left off, in the event, for example, of a case needing to be transferred from one CCW to another, or one organization to another;
- fosters accountability of providers: are people doing what and they have agreed to in the care plan and on an appropriate timeline;
- is needed not only on the level of individual cases, it is needed in order to track the functioning of the system, and provide information to the various levels of stakeholders, including provincial and national level players, as well as donors who support activities within the system;
- helps establish trends that inform programing to best meets the needs of children.

1. Case files

Case Files are to be opened for every individual case, as soon as an intake is initiated, unless it is quickly determined that no action is needed (see Intake: Chapter 3, section 1). This is done using a flat file with an individual case number assigned. Each file should detail the client's case history from their initial assessment to present date. All written records must be dated and signed by the person making the entry. Case files should be kept safely secured and in good condition at all times in the event that they are required for:

- continuity of care and support in the absence of the original case worker or authorised representative;
- evidence in criminal proceedings;
- monitoring that actions taken were in the best interest of the child;
- supervision.

The case file is kept locally, though records of child abuse and neglect reports are maintained by the DCWPS or social service agencies to aid in the investigation,

treatment, and prevention of child abuse cases. When a child with a care plan in the case management system has been referred to DCWPS for intervention due to abuse, the referral should be clearly recorded in the chart. DCWPS should communicate the status of the case back to CCW. When the child has been referred back to the community care workers, these communications should be documented in the case file, as they are significant to the overall care plan and ongoing support being offered by the CCW and others involved on the community level.

The Case File should include:

- Intake and Allocation Form
- Assessment and Case Plan Form
- Record of Significant Events and Contacts (see below)
- Narrative explanation of any documented events or contacts that require further description to understand the child and/or family and the care being provided;
- Any subsequent assessments and care plan revisions;
- All other relevant documents available on the child, e.g. copy of birth registration; copy of parent's death certificates; information sent to or received from collaborating organizations.

For the sake of clarity and ease in reading the file, completed sections- the intake, assessment and care plan, document of significant events, corresponding narratives, case review/revised care plan, and subsequent significant events sheets and narratives, should be clipped together in the order listed above. Other documentation, such as copies of birth and death certificates, can be grouped separately.

All contact, whether it seems important or not, with the child or family members, as well as observed or reported events of significance should be noted in the **Record of Significant Events and Contacts** form. These include:

- contact between the child/family member and the CCW or any other involved person related to the case management work; whether a face to face meeting or telephone contact;
- changes in behaviour or mood: observed or reported;
- details of any accidents or injuries (seemingly significant or not);
- significant achievements;
- significant interactions between the child and others that case management team members should be aware of, whether observed or reported;
- meetings the child has with any person or organization involving needs addressed on the care plan;
- referrals made to other organizations or individuals to provide resources or care to the child;

- any other information which may be considered relevant to the ongoing case.

For any visits that require more description to capture important information, an additional page with this narrative should be dated and put in the case file. Examples of visits that require more documented description are ones where the child or a family member discusses an experience of importance that others on the case management team should know about, or an observation made in the home that is significant, such as a conflictual interaction between the child and the guardian.

2. Information Sharing in the Case Management System

Case Management is driven by the need to ensure proper and holistic care for children in need of services. To achieve this goal, information sharing and recording becomes a key component. Care workers need to fully record all their interventions as guided by the case management recording forms. The recorded information serves multiple purposes including care planning, accountability purposes and for feeding to the National MIS.

The reporting structure of the case management system guides the flow and exchange of information. The table below gives a synopsis of the information shared across the layers in case management.

Level	Information Shared	Considerations
CCW	CCW extract information from their case files and compile a monthly case summary sheet. The monthly case summary sheet synthesizes the cases under their care and outlines identified needs and services rendered.	CCWs need to be assisted by the LCCW in maintaining up to date and coordinated case files. The information submitted in the monthly case summary sheets is obtained from the case files.
LCCW	LCCWs are the link between the community and the District level. The LCCWs compile information from the community and submit it to the District level, and also	The position of the LCCW is very important as it serves as a bridge between the District and the community level.

	provide feedback from the District to the community. The LCCW also gathers all the necessary information that will be fed into the National MIS	
District	At the District Level, all the data from the wards is compiled into a District Report. The information is both quantitative, via the statistical reports and qualitative from the monthly narrative reports. A District MIS will capture the cases being handled within the District	The compilation of information from the LCCWs is both an information gathering as well as an information giving platform. As cases are reported and complied, the DCWPS gives feedback to guide case management in the community.
Provincial	Reports are submitted from the District to the Provincial level and then compiled into a provincial report. The reports will assist in painting a picture of the provincial child protection issues. The information can assist in key programming issues and decision making at the provincial level.	Accurate information at the provincial level is critical in helping understand the distribution and prevalence of cases and can ultimately assist in the decisions and responses needed.
National	The National level compiles all the Provincial reports into the national database. The information is then fed into the National MIS system.	The information compiled at the national level is critical for policy development and the identification of programming gaps.
CPCs	As a multilevel structures, CPCs are important from the community right up to the national level. The work of all the child care workers has to be aligned to the work of CPCs. The CPCs also keep a	CPC are key at all levels and given this, all the child protection work has to be reported to the corresponding CPC level and overall guidance from the CPC

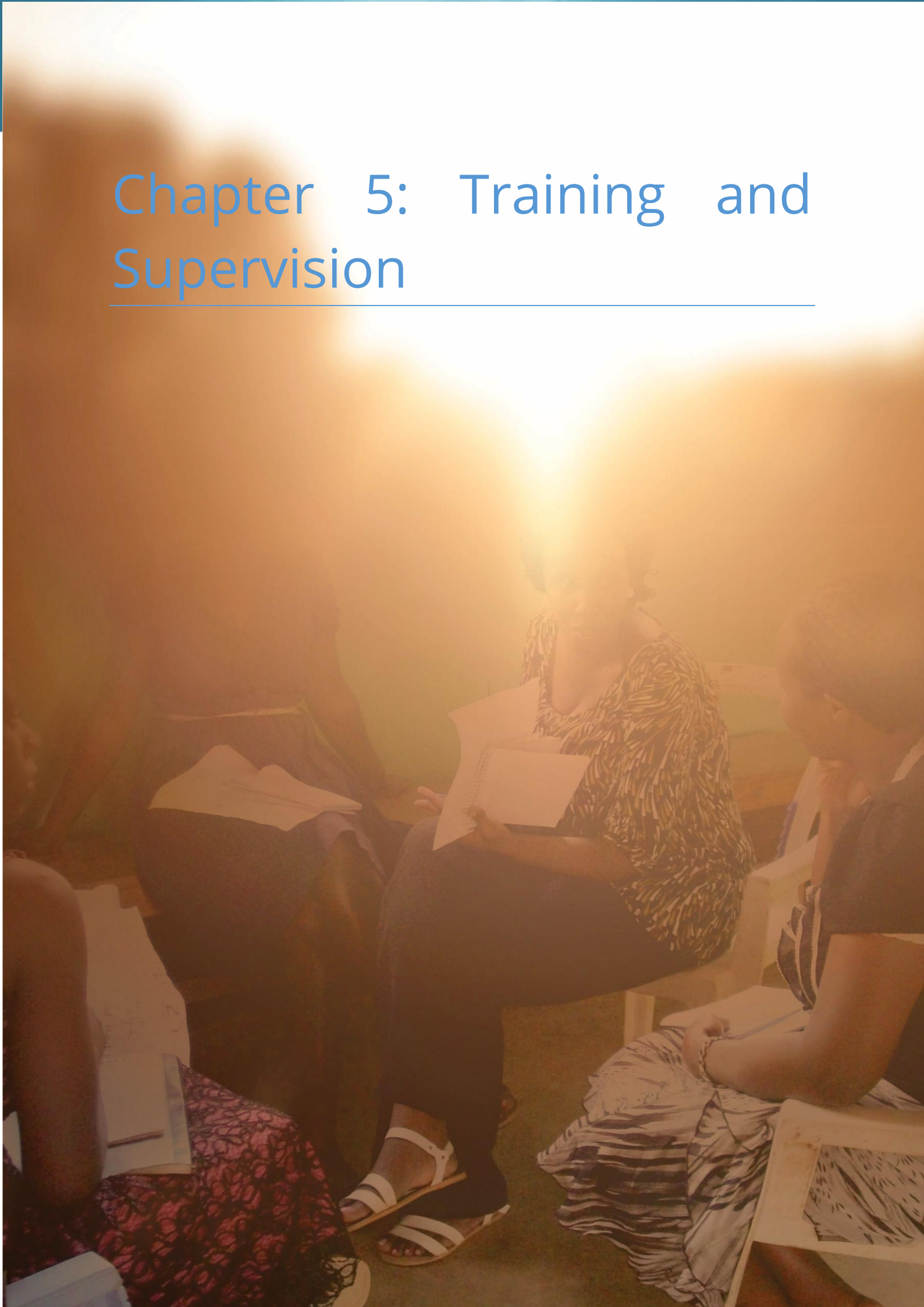
	record of all the child protection concerns emanating from their areas of jurisdiction.	should always be sought.
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While information sharing in case management generally follows the structure outlined above, in practice, the specifics about individual cases influence that actual reporting process. For example, some particularly complex cases might rope in many care cadres from across service providers. Having these multiple participants involved may influence the way the information is moved through the system.

While information on care being provided moves up through the formal structure, it is necessary to determine what information needs to be shared with whom in order to provide optimal care to each child on a case by case basis. Communication between various parties serving a child is necessary in order to coordinate the care that is needed. In keeping with the principle of the best interest of the child, care workers can share information with other key players across the case management system as determined by the needs of the case. In sharing information, it is vital to ensure adherence to the principle of confidentiality, sharing information only with people who need to know, and always involve the child and family in, or inform them of, the key processes that will be taking place.

It is important to note that while information sharing is required in the provision of integrated care, it also carries the possible risk of exposing the children to more harm, especially in community settings. Given this reality, the issue of confidentiality versus information sharing with relevant people requires particular attention at the community level. Significant efforts should be made to ensure that care workers are mindful of the possible risk to the child if they act without adequate thought to the ramification of their actions. Care receivers need to be made aware of how, with whom and for what purpose the information will be shared.

Chapter 5: Training and Supervision



Section 1: Training

The National Case Management System heavily utilizes volunteers. Prior to beginning child care work, LCCWs and CCWs must be provided adequate formal training. This training provides basic coverage of concepts needed for assessing and working with vulnerable children, with specific attention to children who are experiencing, or at risk of experiencing violence and abuse. Included is the structure, function and requirements of the Case Management System, as well as material on child development, the effects of neglect and abuse, and basic child and family assessment, counselling skills and supervision. In addition to the initial training, intermittent, on-going education to promote skills development will be provided through follow-up trainings and regular clinical supervision.

Section 2: Supervision

The sustainability of the case management system hinges on effective supervision of the care cadres. Supervision in the case management system is derived from the clinical supervision model. Clinical supervision is based on the understanding that developing and maintaining quality practices on the part of a professional care giver or trained volunteer requires close guidance from an “expert” or senior clinician, as people with limited experience learn the art of applying theory to practice. The senior clinician is supposed to provide the supervisee with support in dealing with issues emanating from being a care giver and empower them to learn to come up with their own well informed assessments and decisions surrounding challenges presented by the work.

The National Case Management system rests heavily on a large pool of trained community volunteers at its base. The fact that these community cadres are engaged with often complex and challenging cases, warrants the need to support them in the delivery of care. Supervision serves the function of improving service delivery by attending to the questions and needs of the care provider, building their feelings of competence and their ability to deliver of the expected services.

The functions of supervision are three-fold: administrative, educational and supportive. Its overall purpose is to:

- enhance the quality of care;
- promote the development of knowledge and skills;
- provide multiple perspectives for understanding cases or problems encountered;
- provide multiple perspectives on interpersonal dynamics inherent in case work;
- provide support and address issues around secondary trauma, compassion fatigue and burnout.

Child care work, like any other direct service provisioning, can be a difficult job. The complexities associated with the work can lead to stress, burnout or compassion fatigue resulting in the care worker being temporarily unable to adequately tackle presenting issues. In the case management context, supervision provides the opportunity to share experiences and address the concerns of the workers which, ultimately, builds their capacity to provide care. Additionally, the need for accountability to the recipients of services makes supervision a critical component as it supports the child care worker in providing correct, effective and appropriate services.

These supervision meetings should have a clear agenda which may include but are not limited to the following:

- Care worker notification of upcoming leave days to ensure cases are in good shape before going on leave and adequate cover is arranged;
- Staff development issues such as training;
- Concerns about work;
- Case discussions based on case priority; and
- Case allocations.

Peer supervision will concentrate on the educational and supportive functions of supervision. These meetings will also have a clear agenda, but this agenda will focus on case discussions, sharing ideas about managing problems encountered or strategies successfully employed, as well as discussion on the emotional strains of the work and ways in which these can be handled. This latter aspect is important in that it both decreases the isolation that can be experienced in providing direct care to children and families, and it provides an opportunity to learn from others facing similar situations and coping with similar stresses.

Levels of Supervision in Case Management

For the purposes of this National Case Management System, supervision levels are set along the reporting structures in the case management framework. However, there must be a clear differentiation between clinical case management supervision and routine task performance supervision. At the District Level, the DCWPSO has the overall responsibility of supervision of the staff. The DCWPSO provides supervision for the LCCWs, and the LCCWs supervise the CCWs.

Conducting Peer Supervision Groups

Given the large numbers of CCWs compared to the limited number of DCWPS officers, most of the supervision within case management will be done in the community, using a peer supervision approach. Peer supervision can be defined as the formal support that care givers at the same level can give to each other in a platform designed to deliver supervision functions. It is important to note that peer supervision serves the same functions as highlighted above with the difference being that there is no structure of seniority between the supervisor and supervisee.

Conditions that are pivotal in peer supervision are;

- Creation of a supportive environment that allows the supervisee to openly present a case and highlight the struggles they face in the management of the care;
- Participation on the part of all group members geared toward building the capacity of themselves and each other through a willingness to ask questions and explore the case critically;
- An environment that empowers participants to explore challenges and come up with their own answers, as opposed to looking to others to be told what to do;
- Ability of the group to provide support that validates concerns of the one presenting, thus reinforcing a sense of being understood.

The structure of a peer support group is critical to its functioning and survival. Ideally, a group is made up of 5 – 8 members. Larger than 8 or 9 is difficult because it gets too large for everyone to be a regular contributing member. Because all groups have people who are more and less talkative, the larger the group the greater the likelihood that the quieter members will end up saying very little and become marginal members of the group. Four or fewer members can pose challenges, as the absence of one person significantly changes the feel of the group. However, in sparsely populated areas where few CCWs are located near one another, peer supervision can be conducted in as small a group as a dyad. In cases such as this, the group will benefit from additional support from the LCCW, for feedback on the issues that come up with their cases, the main points of the discussion that ensued, and some additional support in brainstorming when needed.


Guidelines for the process are as follows:

- Each meeting should be conducted by the “leader” for the session. Leading the session means keeping time and helping the group stay focused on the issues at hand. The position of leader, or facilitator, should rotate through the group members, with a different person assuming the role each meeting. The leader for a meeting should be designated at the close of the previous meeting.
- Meeting length should be 1 ½ - 2 hours, depending on the size of the group.

- Set the agenda and time frames accordingly.
- Presenters for each meeting should be chosen ahead of time to enable adequate preparation for a case and the related problems and questions to be presented succinctly and coherently. The care worker should present a case highlighting the background, key points from the assessment (strengths of the child and family as well as challenges), care plan and reflections on the case. Of importance are questions, or the reason(s) that this case is being presented. What is it that the care worker is finding difficult? Others can then ask questions that will help in the reflections on the case. From the discussions, the worker should be able to share thoughts, feelings and perceptions towards the case. Brainstorming may also be helpful, as it is likely that others have come across related challenges at different times. The outcome of the supervision should be the worker feeling more competent and confident to handle the case.
- Emergency cases or pressing problems that have arisen should be able to take precedence over previously scheduled cases if need be.
- The group should decide on how many cases they want to address in a given session. In a 1 ½ or 2 hour session, generally 2 or 3 cases can be adequately discussed.
- Group members should rotate presentations, so that all group members have the opportunity to present regularly.
- In addition to the needs of the client and family, when presenting cases it is also a venue to discuss the stresses the worker is experiencing in a specific case and ways these stresses might be handled.
- The experience and management of work related stress experienced by caregivers in general due to engaging in the difficult problems encountered, not necessarily related to a specific case, is also an appropriate topic for peer supervision.
- Allocate the final 5 minutes for identifying the main issues discussed and follow-up plans. Facilitator documents these on the report form (see Reporting below)..

Reporting

While the purpose of the peer supervision groups is not to evaluate any given case worker, it is concerned with the promotion of overall quality care to the children being serviced. It is important that the system be accountable for the care that is given to children in Zimbabwe. To help meet that goal, it is important to capture information on what is arising as issues of concern, how these issues are addressed, or the level of comfort in addressing these problems on the part of CCWs. Unlike the case record,



which gives detailed information on a specific case, the supervision reports provide a way to get a better understanding of the big picture. Also, since ongoing skills development is one of the goals of the peer supervision groups, the information captured over time will give a picture of how people are managing the problems they are coming up against, what areas are in need of further training, or what type of support is needed.

The reporting form with sample lines completed is provided in Appendix IIB. The example given shows the type of information and level of detail that should be reported at the end of each group. The supervision group should allow 5 minutes at the end of each session to identify the issues to be reported. It is the responsibility of that meeting's facilitator to record the information for reporting on the Peer Supervision Groups Report form. The LCCW will compile the supervision reports monthly and forward them to the District Head at the DCWPS. The DCWPS will maintain these records so that supervision can be tracked across the system.

Appendix I

Case File Forms

The forms included in this manual are to be used as guides. While they can be taken from the manual and used as they are, many organizations have and prefer their own forms. However, it is important that the information included in these is present and easily identified in whatever forms are used.

Appendix 1A

Intake and Case Allocation

Name of the Child: _____

Date of Birth of Child: _____

Check one: have documentation _____ or estimated _____

Address of Child: _____

Date of Referral: _____

Reason for referral: the nature of the concern, how and why has it arisen, does the concern involve violence or abuse?

Is emergency action required? Police (ZRP), emergency medical services, out of home placement?

Name and Details of Person Making Referral	Relationship	Age	Address and Phone number

Parents* or Guardians			
Father*/male guardian		Mother*/female guardian	
Name		Name	
D.O.B/age:		D.O.B/age:	
Occupation		Occupation	
Address		Address	
Telephone		Telephone	

*date if deceased or abandoned		* date if deceased or abandoned	
--------------------------------------	--	---------------------------------------	--

Details siblings and other significant relatives			
Name	Relationship	Age	Address (if different) and Phone number

Decision	Why was this decision taken
No further action needed	
More information required - detailed assessment	
Emergency action and detailed assessment	

Name _____ Date: _____

Signature: _____

(Person Completing Intake Form)
Case Allocated to (name of CCW/ LCCW/ social worker/other)

Name _____ Date: _____

Signature: _____
(DCWPSSupervisor)

(Person Completing Intake Form)
Case Allocated to (name of CCW/ LCCW/ social worker/other)

Name _____ Date: _____

Signature: _____
(DCWPSSupervisor)

Appendix 1B

Assessment and Care Plan

The assessment helps to gather information about a child so that we can identify what his or her needs are and make a plan to meet those needs. Full details of the child's circumstances are found on the initial intake and allocation form

Child's Name:

Date of Birth:

Name, occupation and contact details of person completing the assessment:

Date of referral:

Reason for referral/child protection concern:

Dates of visits/ to the child's family home or contacts with the family to gather information for assessment

Date & Time	Details of visit	Name/Signature (of primary person interviewed)

Dates of significant contacts with other professionals (ZRP/health/education etc.) to gather information for assessment

Date & Time	Details of visit	Name/Signature

Family: Parents and Caregivers

Describe the child's family/household, including extended family. Any significant losses (deaths or separations from significant family members)? Who are the primary supports in the family/home?

Survival

What is your assessment of the ability of the child's family to provide basic care, shelter, clothes, food etc?

General Health

Does the child have good general health? Has he/she received all necessary immunizations? Does the child have any health conditions which his carers need to be aware of? Is the child properly nourished?

Development

Is the child reaching his/her developmental milestones? Is he/or she walking, speaking, developing self-help skills appropriate for his/her age? Does he/she present with cognitive development appropriate for age?

Behaviour

Is the child's behaviour appropriate? Does he or she present with aggressive behaviour? Appear withdrawn? Exhibit risk taking behaviour? Any recent significant behaviour changes?

Social interactions

Describe the child's social world outside the home, e.g., friends, relationships with teachers, pastor, or other non-family member adults; interests and activities. Any significant recent changes?

Education

Describe the child's educational abilities, performance, achievements and any areas for development

Other organizations

List the name and purpose of any other organization that is already involved in providing services to the child or family,

Child's comments on the assessment; Complete "My life now" prior to discussion
Does the child want to add anything about his or her hopes, dreams and aspirations or general information relevant to the assessment?

Conclusions

Paint a picture of the child in words: describe the child briefly and include his or her good points as well as any areas for concern.

What needs to change so that the case can be closed? Describe the desired changes in the child's situation and how you will assess that he or she is no longer at risk of harm.

For complicated cases, it may be important to hold a case conference. This will enable all relevant people to come together discuss the various issues and challenges with which the child and/or family are confronted. The joint discussion will allow for the development of a more comprehensive care plan.

Case Conference: Yes: date: _____ No _____

If yes:

Participants in Case Conference:

Agreements of Case Conference:

1)

2)

3)

4)

5)

Care Plan

Overall Objectives of the Care Plan

What are the main goals for the child e.g. to return home to his or her birth family; to live with relatives; to improve educational opportunities; improved health care; overcoming trauma etc.

Agreement of the Parents/Family

Name	Signature	Date
------	-----------	------

Agreement of DNRS (responsible case worker)

Name	Signature	Date
------	-----------	------

Agreement of the Child

Name	Signature	Date
------	-----------	------

Date of Next Review:

Appendix 1C

Record Of Significant Events And Contacts

Childs Name: _____

Date	Details of Contact	Signature of person recording

Appendix I D

Referral Form

To be completed in duplicate. One copy kept by referring organization, one by organization receiving the referral.

Name of Child: _____ Date: _____

Date of Birth: _____ Sex (M/F): _____

Name of Parent/Guardian: _____

Address: _____

Phone: _____

Details of problem/need: _____

Reason for referral:

Referred By (Name): _____ Title: _____

Organization: _____

Address: _____

Phone: _____

Referral sent to: _____

Address: _____

Phone: _____

Responsible Referring Signature: _____


Follow-up (to be sent back to referring agency)

Phone or written confirmation that referral is received and accepted (please ☐ check)

Date _____ seen: _____

Findings: _____

Plan: _____



Date reported back to referring organization: _____

Name, title: _____

Signature: _____

Appendix 1E

Case Review/ Care Plan Update

DATE OF REVIEW and CARE PLAN REVISION:

Completed (check all the apply)

1. First assessment reviewed with child and caregiver for progress and changes
2. Previous action(s) plan reviewed
3. Significant events log reviewed
4. Problems or needs new since last care plan discussed with child/family
5. Child has filled out new "My Life Now" if age appropriate
6. New care plan developed
7. Care plan signed by all relevant parties
8. New care plan discussed with LCCW

REVISED CARE PLAN

Overall Objectives of the Care Plan

What are the main goals for the child e.g. to return home to his or her birth family; to live with relatives; to improve educational opportunities; improved health care; overcoming trauma etc.

Action Plan to Achieve Overall Objectives			
Action	How Often/When	Person Responsible	Expected Outcome

Agreement of the Parents/Family

Name

Signature

Date

Agreement of DNRS (responsible case worker)

Name

Signature

Date

Agreement of the Child

Name

Signature

Date

Date of Next Review:

Appendix 1F

Case Closure

DATE:

Name and signature of person completing the form:

Name and signature of supervisor;

Reason for closure: (check one)

All objectives met. Closure is agreed upon between case management team, child and parents/caregiver ____

Child died ____

Child moved away (informed of right to have case sent to new location ____

No longer wants services (exploration of reasons and efforts to alter choice documented) ____

Can no longer find child ____

Process completed: (check all that apply):

- There been discussion with child and or family, and are they in agreement with the decision. ____
- Problems have been adequately addressed and there are no longer concerns for the child's safety. ____
- The goals of the care plan have been met. ____
- The child been made aware of the resource available if another child protection need arises. ____
- The child is electing to end services against the advice of the care worker. ____

Description of the decision: (use back of form if additional space is needed)

- If goals of the care plan have been met, describe the current situation of the child in terms of the objectives and activities in the care plan.
- If the child is electing to end, describe the attempt(s) to work out the issues on ways other than ending services.

Appendix II

Reporting Forms

Appendix IIA ?

Monthly Case Summary Sheet (CCW)

Name and surname of Child	Sex of child	Case file No	Date of birth/ Age	Assessed Needs	Services Received so far	Outstanding Services required	Services referred for	Outcomes of the referrals	Comments on the case

Appendix IIB (what to keep?)

CCW Monthly Statistical Report

DISTRICT: Ward:
NAME OF CCW:Verified CPC
Chair.....
MONTH:.....
DATE OF SUBMITTING
REPORT:.....

Category for Case Management	New Cases Identified	Continuing Cases	Closed Cases	Total Cases Attended	Comments(include sex aggregate)
Children not attending school					
2. Children at risk of being abused					
3. Abused children, (sexual, physical, neglect, verbal etc)					
4. Children not adhering to medication					
5. Children living in extreme poverty					
6. Abandoned children					
7. Children in conflict with the law					

8. Child headed families					
9. Children living with disabilities					
10. Children with health problems					
11. Children living in broken homes					
12. Children in domestic violence					
13. Children without birth certificates					
14. Married children					
15. Pregnant children					
16. Orphaned children					
17. Children living with elderly guardians					
18. Children living with chronically ill guardians					
19. Other					

NB: ALL COMMENTS TO INCLUDE GENDER IN EACH CATEGORY

Objectively Verifiable indicators (OVIs)							Comments
			New children this month	Continuing children this month	Total Children For The Month (new and old)	Cumulative Total	
	By Age						

Total number of direct beneficiaries receiving a service (disaggregated by age and gender)	0-5yrs	Fem					
		ale					
	6-10 yrs	Fem					
		ale					
	11-15 yrs	Fem					
		ale					
	15-17 yrs	Fem					
		ale					
	Total						
Total number of beneficiaries receiving a referral service only (disaggregated by age and gender)	0-5yrs	Fem					
		ale					
	6-10 yrs	Fem					
		ale					
	11-15 yrs	Fem					
		ale					
	15-17 yrs	Fem					
		ale					
	Total						
Total number of individuals receiving information only (disaggregated by	0-17 yrs(children)	Fem					
		ale					
	18+(adults)	Fem					
		ale					
	Total						

	age and gender)						
	Number of children		Female				
	Case		Male				
	Managed according to Minimum Standards for the Care and Protection of Children.	Total					

NB: COMMENTS TO INCLUDE NATURE OF SERVICE RECEIVED

Appendix IIB

Peer Supervision Group Report Form

LCCW		Month		
Supervision group: number attendance	Date(s)	Cases presented: case category	Issues/topics discussed	Issues requiring follow-up
Sample Group 15	18/02/14	At risk of being abused	<ol style="list-style-type: none"> 1. Suspected sexual abuse, or inappropriate relationship between child and uncle 2. Family resistance to discussion with CCW-how to handle, 3. CCW experience-stress experienced by intervene in a hostile family 	<ol style="list-style-type: none"> 1. Questioned abuse and how to handle, will discuss with LCCW and DCWPO/CMO 2. Discussion with other CCWs on how they deal with resistant or angry family members in homes
Sample Group 15	18/02/14	Not attending school	<ol style="list-style-type: none"> 1. School fees and inappropriate action of headmaster-how to handle this 	<ol style="list-style-type: none"> 1. Discussion with headmaster along with aunt, and village chief following discussion with headmaster if the issue does not appear resolved

Appendix III

Monitoring And Evaluation Tools

APPENDIX IIIA

Psycho-social Well-being Quality Tool “My Life Now: Ask the Experts”

What we mean by psychosocial wellbeing: how one understands and feels about him or herself and the outside world that shapes this, and the resulting impact on the ability for someone to live a meaningful life

Code: _____ Age: _____ Girl or Boy: _____

The content of this questionnaire have been explained to me and I agree to be included in the study.

Signature:.....

Date:

Please circle one response from each question

INTERPERSONAL

- A. Joy: happy to sad
 - 5. I am nearly always happy
 - 4. I am usually happy
 - 3. Sometimes I am happy and sometimes sad
 - 2. I am usually sad
 - 1. I am nearly always sad

- B. Hope: feeling about the future
 - 5. I have a lot of hope for my future
 - 4. I feel “ok” about my future
 - 3. I am uncertain about my future
 - 2. I am fairly worried about my future
 - 1. I have no hope for the future

C. Self-esteem: feeling about yourself

5. I am quite proud of who I am
4. I generally feel good about myself
3. I feel just "ok" about myself
2. I mostly feel bad about myself
1. I feel I am worthless

D. Confidence: feeling about ability to get things done

5. I am really good at most things I do
4. I am good at some of the things I do
3. I am average at things I do
2. There are many things I can't do that I should be able to do
1. I can't think of anything I do well

INTRAPERSONAL

E. Stigma: how treated compared to peer group (meaning peers in general population) This question also relates also to understanding and respect from others.

5. My friends understand and treat me very well
4. Most of the time I feel pretty good about how my friends relate to me
3. In some ways my friends make me feel like I am different from them and this doesn't feel good
2. Only on a few times am I treated as well as my friends
1. I am never treated as well as my friends

F. Love and (emotional) caring

5. I have an adult who fully loves and cares about me
4. I have an adult who loves and cares about me, but sometimes it is not fully expressed
3. I have an adult who cares for me, but I'm not sure if they love me
2. I don't have an adult who cares for me
1. There is no one who loves and cares about me

G. Guidance and help

5. I have an "adult" (translate auntie/mother) who is very helpful in assisting me when I need help, assistance and guidance
4. I have an "adult" who helps and guides me, but sometimes not completely
3. I have an "adult" who helps and guides me, but often I can't count on this
2. I don't have an "adult" who helps and guides me
1. There is no one who helps and guides me

SAFETY

H. In Home:

5. I feel very safe from violence or abuse in my home.
4. I am fairly well protected from violence or abuse in my home
3. Sometimes I am fearful of violence or abuse in my home
2. I am fearful of violence and abuse in my home
1. I am very fearful because I regularly experience violence or abuse in my home.

I. **In School:** (those going to school, or of school age and has gone to school at times)

5. I feel very safe from violence or abuse in my school
4. I am fairly well protected from violence or abuse in my school
3. Sometimes I am fearful of violence or abuse in my school
2. I am fearful of violence and abuse in my school
1. I am very fearful because I regularly experience violence or abuse in my school

(if not in school and working, answer Question K below)

J. **In Community:**

5. I feel very safe from violence or abuse in my community
4. I am fairly well protected from violence or abuse in my community
3. Sometimes I am fearful of violence or abuse in my community
2. I am fearful of violence and abuse in my community
1. I am very fearful because I regularly experience violence or abuse in my community

SOCIAL INVOLVEMENT

K. **When working** (for those not in school, work includes subsistence, cash income, a care giver to young or disabled child)

5. I feel good about my work and how this helps me or my family
4. The work I do helps me and my family but it is not satisfying
3. The work I do isn't nearly enough to help me or my family
2. In my work I am treated very badly by others.
1. I have no work and feel very bad about this

L. **Friendship and getting along:**

5. I have friends who I trust, support each other and get along
4. I have friends who I trust and we support each other but sometimes we have difficulties that upset me but these don't make me sad for too long
3. I have some friends I trust and get along with and others who regularly cause problems for me.
2. I don't have many friends.

1. I don't have anyone who I can call a friend

M. Problem solving (solutions to challenges)

5. I don't get too upset with problems that i face and can work through them without too much difficulty
4. Problems generally don't upset me too much, but sometimes I struggle in working through them
3. Problems do upset me sometimes and I sometimes struggle in working through them
2. I have difficulty in working out how to resolve problems
1. I have a lot of problems and can't work them out

N. Community-wide access for help

5. I know many people to talk to and many places where I can go and get help in my community if someone is hurting me or I have an emergency
4. I know one person to talk to and get help, and am aware of another place I can go to get help if someone is hurting me or I have an emergency
3. I know someone to talk for help, but I'm not really sure where else I can go and get help if someone is hurting me or I have an emergency
2. Only few times do I have someone to talk to for help, and I have no knowledge about where else I can go and get help if someone is hurting me or I have an emergency
1. I do not know anyone to talk to in my community when I need help if someone is hurting me or there is an emergency


O. Participation in community groups

(Can be answered by youth of the age to participate, or caregivers of very young or child with disabilities who can't respond) List of activities include: support groups, artistic or cultural activities, sports, religious

5. I am involved in a lot of activities in my community, and am a leader among my peers.
4. I am involved in a number of activities in my community and enjoy them.
3. I am involved in few activities in my community.
2. Sometimes am involved in activities in my community
1. I am not involved in any community activities

GENERAL QUESTIONS

1. In recent months, there has been improvement in my life (or my child's life) and feel better about my ability to improve it. Yes ☐ No ☐
2. "I have seen improvement in my life since I started getting assistance from an outside organization" Yes ☐ No ☐



Thank You

Appendix IIIB

Quality Checklist Tool for Case Files and Coordination

Quality Categories and Components	Yes	No	Comments/Explanations
I INTAKE INFORMATION is well documented	n/a	n/a	
1.Child, parent, caregiver names and contact information			
2. Reason for intake and who is making the referral			
3. Provision of Child Friendly Resource			the beneficiary is informed of rights and what to expect from the service provider
II. CASE PLAN exists and is dynamic	n/a	n/a	based on the individual needs of the beneficiary
4. An assessment is undertaken and documented			In health, safety, shelter, care and livelihoods
5. A plan of action is developed with timeframes and key activities, based on assessment			
6.The beneficiary (and/or care giver) informs and participates in the case plan			
7.The most critical interventions are prioritized			

8. Plans are reviewed by colleagues and/or supervisors, and partners			Also called “case conferencing” evidenced through regular or special meetings as needed
9. As needed, the case plan adjusts based on changing circumstances			
III. CASE NOTES provide comprehensive documentation of activities	n/a	n/a	Also called “case logs” or “record of significant events & contacts” ie calls, letters, meetings, referrals, visits, advocacy
10. Notes in case logs are clear and timely			
11. Dates and responsible parties are noted, case entries are signed or initialed			
12. Case notes are organized to show progression of case plan implementation			
IV. REFERRALS and services are well coordinated	n/a	n/a	
13. Effective referral forms are being used to enable access to other service providers			
14. A follow up system exists to best ensure beneficiary access to referral parties			Can include direct referral, client led referral, and advocacy done if referral not effective
15. Case file documents results of referrals			Not in compliance if referral made and there is no documentation on follow-up
V. Beneficiary WELLBEING is clearly documented	n/a	n/a	
16. Indicators of quality are clearly evident in the objectives of the case plan			
17. Quantitative and qualitative indicator results are easily identified for program reporting			
18. Rationale exists and documented for case closure, case file is complete upon closure			Includes all documents/ forms to case file (a list exists), and beneficiary feedback to promises of Child Friendly Resource
VI. Case files are PROTECTED and ORGANIZED	n/a	n/a	

19. Files are secure for confidentiality and longevity			
20. There is organized storage for efficient and long term retrieval			
Total points			Add up all yes answers
% indicator of quality			Yes answers/20

Comment and Analysis Section

Summary of quality case file and coordination indicator per reporting period

Case files reviewed: _____

Average quality % of case file and coordination: _____

Trends in quality measurement, compared to base line and previous quarter

Quarter	4 th 2013	1 st 2014	2 nd st 2014	3 rd 2014	4 th 2014
# case files reviewed					
Quality %					

Identify significant gaps in quality of case file and coordination and plans to address them. Reference the specific components from the checklist (i.e. V.18).

Discuss your plans to further develop your quality case file and coordination system.

Describe the process used (or plan) for quality case file and coordination M&E. This should include safeguards to minimize bias, appropriate number of case files for review in terms of size of case load, and geographic & program diversity.

Case coordination comment and analysis section

Summary of quality case file and coordination indicator per reporting period

Case files reviewed: _____

Average quality % of case file and coordination: _____

Trends in quality measurement, compared to base line and previous quarter

Quarter	3 rd FY 12	4 th FY 12	1 st FY 13	2 nd FY 13	3 rd FY 13	4 th FY 13	1 st FY 14	2 nd FY 14	3 rd FY 14	4 th FY 14	1 st F Y15	2 nd F Y15	3 rd F Y15	4 th F Y15
# case files reviewed														
Quality %														

Identify significant gaps in quality of case file and coordination and plans to address them. Reference the specific components from the checklist (i.e. V.18).

Discuss your plans to further develop your quality case file and coordination system.

Describe the process used (or plan) for quality case file and coordination M&E. This should include safeguards to minimize bias, appropriate number of case files for review in terms of size of case load, and geographic & program diversity.

Appendix IV

The Minimum Standards for Child Care Workers

STANDARD 1: Statement of purpose

There should be a clear statement of the aims, objectives, services provided as reflected in the registration documentation of the organisation. If education or health services, including therapeutic services are provided, these should be covered in the statement of purpose.

STANDARD 02: protect and safeguard children from abuse and neglect

- i. The community childcare workers has the duty to protect each child or young person they work with from all forms of physical, emotional and sexual abuse as well as neglect.
- ii. A written policy safe caring guidelines should be provided to Community Childcare workers in each organisation and the CCW should acknowledge receipt.
- iii. A case management framework should be put in place to collate and evaluate information on the circumstances and outcome of all allegations of neglect or abuse of the child.

STANDARD 03: Appropriate skills and suitability to work with children and families

- i. Community Childcare Workers training should prepare them to work with children who have been abused, safe caring skills, managing behaviour and recognising signs of abuse and ways of boosting and maintaining the child's self-esteem
- ii. Community Childcare Workers should have the basic understanding of the principles of the Children's Act (Chapter 5:06), the regulations and guidance, relevant current policies and procedures as well the referral processes

- iii. Community Childcare Workers should be interviewed as part of the selection process and have references checked to assess suitability before taking on responsibilities.
- iv. Records of police checks and references that have been obtained should be kept. Follow enquiries should be made on all obtained written references. Police checks and community vetting should be renewed every three years.

STANDARD 04: Appropriate skills and ability to manage a childcare service

- i. The managers or supervisors of community childcare service should possess the necessary management skills, knowledge and experience in childcare work. The manager needs to have:
 - a) A professional qualification relevant to working with children, which must be at least certificate or another qualification that matches the competencies required such as care planning, coordination, advocacy, report writing and interpersonal communication skills among others.
 - b) At least two years' experience of working with children within the past five years.
 - c) knowledge of the roles of other agencies, in particular DCWPS, Health and Education

STANDARD 05: Appropriate monitoring and control of Community Childcare workers

- i. There should be clearly documented procedures for monitoring and controlling the activities of the Community Child Care service and ensuring quality performance.
- ii. There should be clearly documented roles for managers and staff and well established lines of communication and of accountability between managers, staff and carers.
- iii. The community child care service informs carers, managers and staff of their responsibility to declare any possible conflicts of interest.

STANDARD 06: Matching Community Childcare workers with the needs of child

- i. An effort shall be made to match Community Childcare Worker's capacity and the identified needs for the child and family especially in cases of special needs and disabilities. Referrals should be made to the appropriate services at all times.
- ii. In matching children with carers, responsible organisations shall take into account the child's care plan if there is one and recent written assessments of the child and their family.
- iii. Matches are achieved by means of information sharing and consideration involving all relevant professionals, the child and her/his family and as well as other children in family and the social support network.

- iv. Where practicable, each child and their family should have the opportunity for a period of introduction to a proposed Community Child Care Worker.

STANDARD 07: Ascertain wishes and feelings of the children and their families

- i. The Community Childcare Worker should ensure that the views of the child and family are ascertained and considered taking into account the age of the child and their best interest of the child.
- ii. The Community Childcare Worker should understand the importance of listening to the views and feelings of the children and need for trained and support in listening and responding to children's views.
- iii. Suitable means should be provided frequently for any child with communication difficulties to make their wishes and feelings known regarding their care and treatment.

STANDARD 08: Care plan to promote the child's developmental needs, e.g health, education, identity

- i. Before a CCW embarks on a case, (s) he should make a full assessment of the needs of the child and its family and feed into the care plan which shall be the basis for addressing the needs of the identified child.
- ii. The CCW shall give high priority to meeting the needs of each child or young person to ensure that (s) he attains his/her full potential.
- iii. The CCW shall help each child or young person on their caseload to access care which meets her/his physical, emotional and social development needs.
- iv. Depending on the child's age, the CCW shall provide the child with information and training appropriate to her/his age and understanding to enable informed participation in decisions about her/his needs.

STANDARD 09: Prepare children for safe and responsible adulthood

- i. The CCW shall help to develop skills, competence and knowledge necessary for the child to enter into safe and responsible adulthood.
- ii. CCWs shall receive training and support to enable them to provide effective support and guidance to young persons preparing to move on to independent or semi-independent living.
- iii. The CCW should provide appropriate counselling and mentoring for young persons on their caseload with a view to provide appropriate opportunities for learning independent skills.

STANDARD 10: Fair and competent organisation

- i. Organisations who engage services of Community Childcare Workers should be fair and competent organisations which provide appropriate support for its Community Child Care Workers as set out in the contract.
- ii. There shall be an out-of-hours management support service available for Community Child Care Workers should the need arise.
- iii. There should be a collaborated and agreed inter-agency form of appraisal to the Community Child Care workers in the WEI programme areas to ensure a standard appraisal framework.

STANDARD 11: Training, certification and registration

- i. Organisations shall provide good quality training programme to enhance individual skills and to keep Community Child Care workers up-to-date with professional and legal developments.
- ii. Foundation Childcare Training delivered by a Child Protection and Safeguarding expert with current demonstrable experience of working with children at senior practitioner or management level shall be the minimum requirement for a Community Childcare Care.
- iii. There should be a clear plan for the training programme and development of CCWs commencing within 7 working days of starting their employment and being completed within 10 weeks.
- iv. A certificate to be provided for training completed which may be useful for registration with the Council of Social Workers and registration renewed annually.
- v. There shall be an appraisal or joint review scheme which identifies the training and review scheme which identifies the training and development needs of all Community Child Care workers in specific communities.
- vi. There shall be regular joint training between Community Childcare workers and staff in organisations working with CCWs.

STANDARD 12: Accountability and support

- i. All staff and CCWs are accountable to their community and they should be supported by their organisations as much as possible.
- ii. All Community Child Care Workers should have clearly written details of the duties and responsibilities expected of them, together with the policies and procedures of the organisation.
- iii. All Community Child Care Workers should receive management supervision and a record is kept by the line manager or supervisor of the content of the supervision and of progress made. Supervision sessions are regular and planned in advance.

- iv. Community Child Care Workers should receive regular, planned appraisals from their line manager.

STANDARD 13: Recording Standards

- i. In meeting these standards in relation to record-keeping, both the organisation and the CCWs shall maintain the records of work done.
- ii. All appropriate records should be kept in a safe and secure place which is accessible to the relevant authorities, Community Childcare Workers and the individual child and family involved.
- iii. Closed cases will be archived in line with the DCWPS policy on case files and disposed of in terms of DCWPS procedures.
- iv. The Community Childcare workers shall be provided with a diary and notes book to maintain an up-to-date, case record maintained for each child or young person on the caseload. Relevant information from the case records may be made available to the child and to anyone involved in her/his care.
- v. There shall be a written policy on case recording which establishes the purpose, format and contents of files, and clarifies what information is kept on the Child carer's files and what information is kept on the child's files.

STANDARD 14: Recruitment and Selection Panels

- i. There should be clearly written policies and procedures of how the recruitment and selection panel is constituted and address the following:
 - a. The handling of their panel's functions.
 - b. Non-discriminatory selection of panellists
 - c. Transparency in the call for interested potential CCWs
 - d. Inclusion of community leadership structures
- ii. There shall be a recruitment and selection panel for each organisation responsible for the recruitment and selection of Community Childcare Workers as well as well as de-registration upon following the due processes.
- iii. There should be independent members of the panel which must include, as far as possible, expertise in education and in child health and the DCWPS may be invited to the panel to express their views.
- iv. Selection panels shall receive management information about the outcome of Community Child Care Workers' annual reviews if necessary.
- v. Selection panels shall monitor the range and type of carers available to the organisation in comparison with the needs of children.

STANDARD 15: Complaints procedure

- i. There shall be a clearly written complaints procedure setting out how to raise any complaints in respect of both the organisation and CCWs, and ensures that they receive prompt feedback on any concerns or complaints raised.
- ii. Formal shall be recorded and this should take into account disabilities and language barriers and **right of reply** guaranteed.
- iii. The complaints procedure shall provide:
 - a. The time scales for dealing with a complain
 - b. The name of designated persons handling complaints in the Human Resources department
 - b. The stages of each complaints and escalation stages
 - c. The Council of social Workers and the Department of Social Services may need to be the involved if a complaint cannot be resolved within the organisation depending on the nature of the complaint.
 - d. A clear structure that is accessible to CCWs and clients including a suggestion box should be put in place

Reference should also be made to the Protocol on the Multi-Sectoral Management of Sexual Abuse and Violence in Zimbabwe⁵⁰ and Pre-Trial Diversion programme⁵¹.

⁵⁰Protocol on Multi-Sectoral Management of Sexual Abuse and Violence in Zimbabwe, Judicial Service Commission, Zimbabwe, 2012.

⁵¹Zimbabwe Pre-Trial Diversion Program for Young Persons, Government of Zimbabwe, 2012.

