USAID
FROM THE AMERICAN PEOPLE

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

4Children
Coordinating Comprehensive Care for Children

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

BUILDING A USER-FRIENDLY AND GOVERNMENT-OWNED CASE MANAGEMENT SYSTEM FOR HIGHLY VULNERABLE CHILDREN

The Yekokeb Berhan Program Experience In Ethiopia

This publication is made possible by the generous support of the American people through the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the United States Agency for International Development (USAID) under cooperative agreement AID-OAA-A-14-00061. The contents are the responsibility of the Coordinating Comprehensive Care for Children (4Children) project and do not necessarily reflect the views of USAID or the United States Government.

Important note: the photographs in this publication are used for illustrative purposes only; they do not imply any particular health status on the part of any person who appears in the photographs.

©2017 Catholic Relief Services. All rights reserved. 17OS079
This material may not be reproduced, displayed, modified or distributed without the express prior written permission of copyright holder.
For permission, write to contact@4-children.org

Table of Contents

Objectives of case study 1
Country overview 1
Poverty and child vulnerability in Ethiopia 1
The social service system in Ethiopia 1
The Yekokeb Berhan program 2
Coordinated care and case management within Yekokeb Berhan 2
Identification 3
Assessment 3
Development of a care plan 4
Enrollment 4
Service delivery 5
Monitoring 5
Case closure 6
Data collection, storage, and use 7
Conclusion: Coordinating care and strengthening sustainable systems 8

Acknowledgements

4Children is very grateful for the gracious collaboration of the Yekokeb Berhan team. The provision of documents and background information and excellent arrangement of the agenda greatly facilitated the process of learning and documenting the case management process. Many thanks to the numerous caregivers, community volunteers, program staff from implementing partners, and representatives of the Ethiopian government for your participation. We hope that we have managed to capture the essence of your experiences within these pages.

Authors
Kelley Bunkers, Suzanne Andrews

Reviewers
Yekokeb Berhan, Maury Mendenhall, Gretchen Bachman

Cover photo
David Snyder for CRS

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
BOLSA	Bureau of Labour and Social Affairs
BOWCYA	Bureau of Women, Children and Youth Affairs
CBO	Community-based Organization
CC	Community Committee
CCC	Community Care Coalition
CSI	Child Support Index
CSO	Civil Society Organization
CSSG	Community Saving and Self-help Group
CV	Community Volunteers
DHS	Demographic and Health Survey
ECD	Early Childhood Development
ES	Economic Strengthening
FGD	Focus Group Discussion
FHI 360	Family Health International 360
HAPCO	HIV/AIDS Prevention and Control Office
HEW	Health Extension Worker
HES	Household Economic Strengthening
HIV	Human Immunodeficiency Virus
HVC	Highly Vulnerable Children
IP	Implementing Partner
KII	Key Informant Interview
MOU	Memorandum of Understanding
MOLSA	Ministry of Labour and Social Affairs
MOWCYA	Ministry of Women, Children and Youth Affairs
NGO	Non-Governmental Organization
OVC	Orphans and Vulnerable Children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PSW	Para-social Worker
SNNPR	Southern Nations, Nationalities and People's Region
SP	Social Protection
SSDG	Standard Service Delivery Guidelines
TVET	Technical and Vocational Education Training
USAID	United States Agency for International Development
WFP	World Food Program

Glossary of Terms

Community Committee: A community committee is a voluntary coalition that is comprised of individuals, groups, and associations that represent different sectors of the local population, government, and other organizations. The community committee is present at kebele and sometimes at woreda level. Within the Yekokeb Berhan Program, the main purpose of the community committee is the prevention of social problems and the amelioration of adverse conditions that affect people (especially children) in difficult circumstances. The intent is for this to be done in a systematic, sustainable manner that can have long-lasting impact on the affected child or family, and can extend – as a system – beyond the life of the program.[1]

Community Care Coalition: A community care coalition is a community-based structure, recognized within the National Social Protection Policy. The National Social Protection Policy describes a CCC as a coalition of community activities that represents different parts of the society, and involves volunteers working to solve and alleviate social and economic problems in their areas.[2] Its primary function is to act as a hub for community leaders to identify, refer, and monitor support to vulnerable populations. This can include but is not limited to the provision of cash grants, enrollment in social service programs, and home visitations by community-based volunteers or para-social workers. CCCs are established by the government and supported with regulations issued by the Regional Government Council. CCCs are present at kebele and woreda levels. CCCs are designed to address vulnerability of all populations, including children, but also the extremely poor, disabled, and the labor constrained.

Kebele: A kebele is the lowest level government administrative unit. A kebele is comparable to a neighborhood or ward. There are more than 30,000 kebeles across the country; the average population of each kebele is 3,000 people.

Para-social Worker: In the past several years, the Government of Ethiopia through the Ministry of Labour and Social Affairs has utilized USAID funding to roll out the training of para-social workers using a government-endorsed curriculum based on approved occupational standards.[3] The para-social workers are recognized positions within the kebele- or woreda-level government structure. They are primarily responsible for working closely with the CCC/kebele to identify, assess, refer, and provide follow-up to vulnerable members of the community (more than just children). In many cases, they also support the supervision of community volunteers. In some cases, community volunteers have been selected to participate in the training program and are now working in their new capacity as para-social workers.

Woreda: This is the second lowest level government administration. It is comparable to a district.

1 Yekokeb Berhan (2014). Yekokeb Berhan Program Standard Operational Guidelines for Implementing Partners.
2 Federal Democratic Republic of Ethiopia, Ministry of Labour and Social Affairs (2013). Social Protection Policy.
3 Federal Democratic Republic of Ethiopia (2013). Occupational Standard Community Service Works NTQF, Level I, II, III, IV and V.

Objectives of the case study

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

The information used to inform this case study was collected during a desk review of relevant project documents and through key informant interviews (KII) and focus group discussions (FGD) conducted during a field visit to Ethiopia in December 2015. In total, more than 30 documents were included in the desk review and discussions were held with 76 people representing Yekokeb Berhan program management, woreda- and kebele-level government, civil society organizations (CSOs), health facility personnel, para-social workers (PSW), volunteers, and caregivers. This process was not intended as an assessment, but rather as an opportunity to observe a case management system in action, speak with those responsible for specific components of the case management system, and hear the voices of those who are served by the case management system.

Country overview

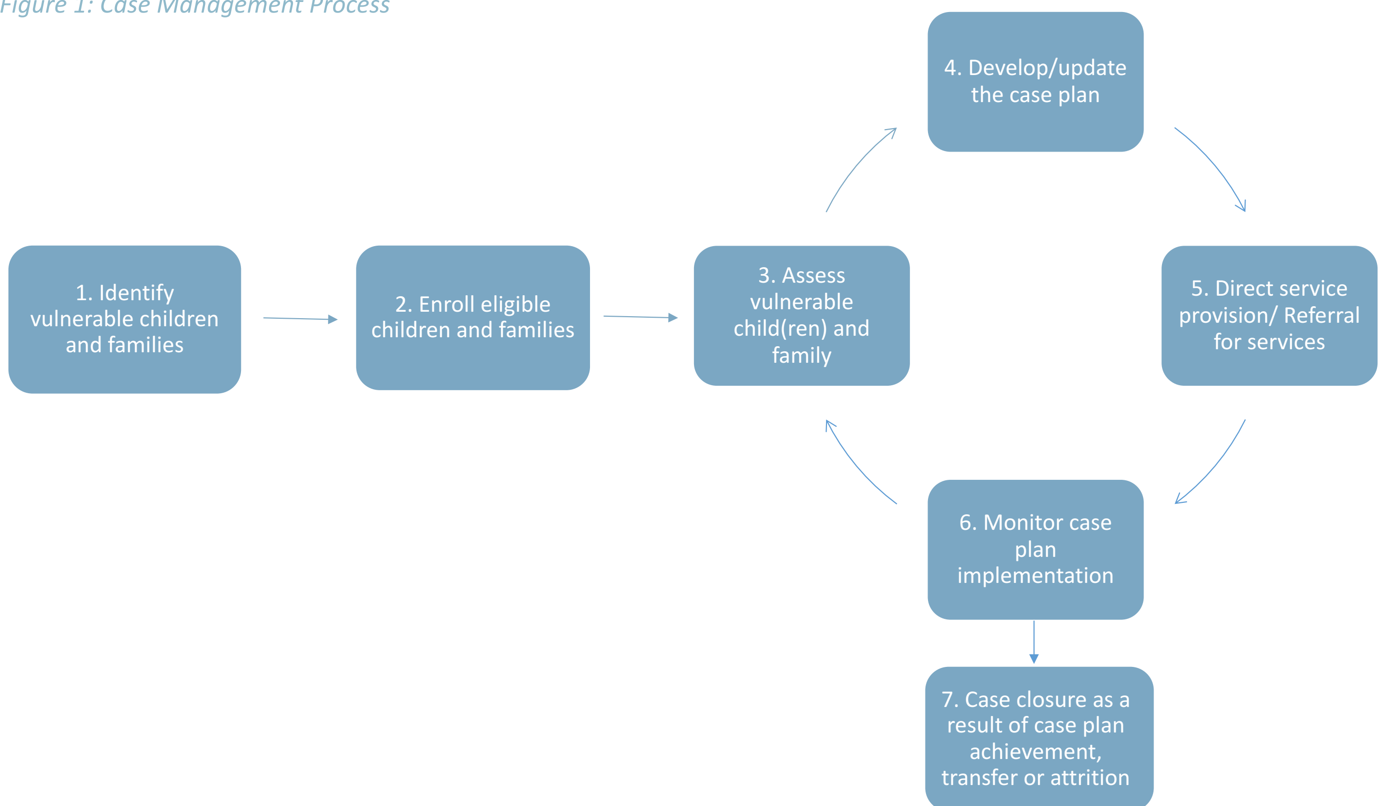
POVERTY AND CHILD VULNERABILITY IN ETHIOPIA

The current population of Ethiopia is estimated to be approximately 95 million.[4] The country has a very young profile with approximately 44% of the population under 15 years of age, and 15% of the total population is under 5 years of age.[5] Although there have been significant improvements in the economic development of Ethiopia in the past decade, an estimated 25 million Ethiopians "still remain trapped in poverty and vulnerability."[6] Children remain vulnerable to HIV and other adversities related to their protection and well-being with an HIV prevalence rate of 1.2%, and close to an estimated 900,000 orphans due to AIDS.[7] Only 7% of children are legally registered, child labor affects more than a quarter of children between 5 and 14 years old, and although access to primary education has improved over the years, 45% of young people (ages 15-24) are not literate.[8]

THE SOCIAL SERVICE SYSTEM IN ETHIOPIA

The Government of Ethiopia has made recent investments in strengthening the social service system, updating the policy framework to add a National Social Protection Policy. This policy includes programs targeting the most vulnerable

Figure 1: Case Management Process



4 Data retrieved from World Bank: http://databank.worldbank.org/data/reports.aspx?source=2&country=ETH&series=&period
5 Data retrieved from UNICEF: http://data.unicef.org/countries/ETH
6 UNDP (2015). Human Development Report for Ethiopia, page 4.
7 Data retrieved from CDC: http://www.cdc.gov/globalaids/Global-HIV-AIDS-at-CDC/countries/Ethiopia/default.html
8 Data retrieved from UNICEF: http://data.unicef.org/countries/ETH.html

Community Care Coalition (CCC) offices

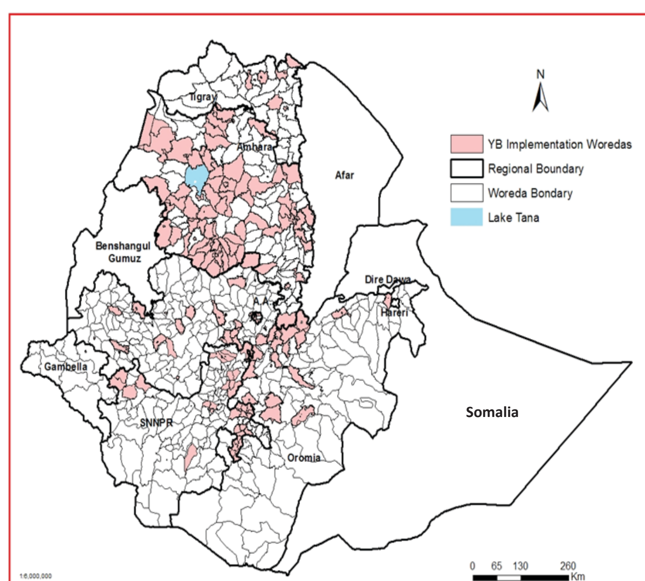
CCCs are government-mandated (supported with regulations issued by the Regional Government Council). Each CCC has a minimum of 10 and up to 23 members – including representatives from local government, NGOs, CBOs, and other local organizations – who attend regular meetings, chaired by the head of the kebele. CCCs focus on all vulnerable persons and their families in the community, including families that are both extremely poor and labor constrained (the disabled, those with chronic illness, advanced age, etc).

populations, the development of a para-professional social service workforce, and the establishment of community care coalition (CCC) offices at the local level (see text box). CCCs are linked, through the local kebele administration, to the woreda-level office of the Bureau of Women, Children and Youth Affairs. In a growing number of kebeles, the kebele administration and institutionalized CCCs are responsible for identifying and managing referrals to services for highly vulnerable community members, including children. The establishment of a local CCC office has provided an important cornerstone from which to build the Yekokeb Berhan program writ large, and the CCC is well integrated into the case management system developed by the program.

THE YEKOKEB BERHAN PROGRAM

Yekokeb Berhan is implemented by a consortium of organizations led by Pact and including Family Health International 360 (FHI 360) and ChildFund. The program has been operating since 2011. During the first three years of the program, Yekokeb Berhan partnered with 50 CSOs, and implemented the program in 239 woredas in nine regions

Figure 2: Yekokeb Berhan coverage by woreda



and two city administrations to support 500,000 highly vulnerable children (HVC) and their families annually. At the time of this report, Yekokeb Berhan was partnering with 34 implementing partners (IPs), and targeting 325,000 HVC and 192,000 caregivers per year. To date, in the four and half years of implementation, the project has served at least 600,000 HVC and nearly 400,000 caregivers. The five-year program is designed to reduce vulnerability among HVC and their families affected by HIV and AIDS by strengthening supportive systems and structures to deliver essential services and increase resiliency.

The key government bodies engaged in the Yekokeb Berhan program include the Ministry of Women, Children and Youth Affairs (MWCYA) at the federal level and through its zonal, woreda- and local-level structures and the HIV/AIDS Prevention and Control Office (HAPCO) and the Bureau of Women, Children and Youth Affairs (BWCYA) and the Bureau of Labour and Social Affairs (BOLSA) at the regional level. Furthermore, at the lowest administrative level, the local kebele administration and the community care coalitions and community committees (CCs) are critical actors engaged in every aspect of the case management process.[9]

Coordinated care and case management within Yekokeb Berhan

Within the Yekokeb Berhan project coordinated care is the term used to describe case management. Coordinated care involves a process of identification, assessment, referral, and follow-up to link children and their families with necessary and locally provided support services." Coordinated care involves a process of identification, assessment, referral, and follow-up to link children and their families with necessary and locally-provided support services. Coordinated care is similar to case management, except that case management generally refers to a series of actions directed toward improving the well-being of *specific* children, caregivers, or families, while coordinated care typically refers to a series of community-level actions or systems of care and support intended to improve the well-being of all vulnerable children and families within a community.

Since Yekokeb Berhan's conception, the program has worked to promote active engagement with, and ownership of the coordinated care process by, local government and other community-based structures. At the lowest administrative level, Yekokeb Berhan engages community care coalitions (CCC) and community committees (CCs) to identify highly vulnerable children and their families, referring them for needs assessments by the community volunteers for care planning, linking them to appropriate services, and monitoring the delivery of services, and the impact of services on well-being. Where CCCs do not exist, Yekokeb Berhan has supported the development or strengthening of community committees (CCs)that perform a similar function as CCCs but are not a part of the formal government system. *The success of coordinated care is largely dependent on*

9 In Amhara and Tigray regions, the kebele administration, together with the CCC, play a major role in the Yekokeb Berhan program. In other regions, coordination functions are performed by a CC under the leadership of BOWCYA. However, the government plan is to eventually establish CCCs in all regions.

effective and efficient mobilization of local communities and local government structures. Without active engagement of local government structures, case management would not function.[10] The community and local government are critically involved from the identification, and play an integral role in the coordinated care process. Community volunteers assigned to work with the CCCs/CCs are recruited from local communities and selected using a few key criteria. Volunteers must be at least 18 years old, in good health, fluent in the local language, able to commit to a minimum of two years of service, genuinely want to be a volunteer (i.e., not pressured to volunteer by others), not have a criminal record, and live in the local community. Volunteers do not need to be literate, but should be able to fill out simple forms and/or able to engage the help of others to complete forms when needed.

The coordinated care approach used by Yekokeb Berhan includes steps that are similar to the case management process described above. A summary of each step in this process and an explanation of the specific tools used follow.

A community volunteer completes a comprehensive assessment of vulnerabilities of the child and household prior to developing a care plan

Photo by David Snyder for CRS

IDENTIFICATION

CCC/CC members are tasked with the identification of vulnerable children using the Government of Ethiopia's Standard Service Delivery Guidelines[11] definition of a highly vulnerable child. The definition is used to determine eligibility and decide whether or not an assessment should be conducted. Members of the CCC shared that they felt that having clear, government-endorsed criteria minimized confusion about which children should be considered the most/highly vulnerable. Community volunteers indicated that the role of the CCC in initial identification (as well as approval for enrollment) takes away the pressure that volunteers might feel to select people they know or community members who have approached them: "*From the beginning the process is transparent and open. We follow the eligibility criteria and that is very clear.*" If a child meets one or more of the criteria, then he or she is referred to an organization that provides services to vulnerable children and families associated with the CCC/CC for further assessment.

Definition of a highly vulnerable child (Government of Ethiopia)

- Child is an orphan (one or both parents died)
- Child is HIV+ and/or the primary caregiver is HIV+
- Primary caregiver is chronically ill (meaning, she or he is often or always bedridden), elderly, or disabled
- Child is known (or appears to be) abused, neglected, or exploited
- Child lives outside family care (e.g., street child)
- Child is exposed to different forms of abuse, violence, and/or exploitation
- Child is in conflict with the law
- Child has an obvious disability that is not receiving care and support
- Child lives in a child- or youth-headed household
- Child is malnourished (moderate to severe)
- Child is unaccompanied due to displacement
- Child is stigmatized or marginalized for other reasons

ASSESSMENT

After the child is identified by the CCCs/CCs, the community volunteer who is assigned from the CSO will visit the family to conduct an assessment of the household and each child in the household using the Child Support Index (CSI), a comprehensive assessment of the economic security, health, nutrition, safety, psychosocial and educational needs, and vulnerabilities of the child and household, as well as HIV and disability status. In total, the CSI contains 20 areas of assessment with discreet indicators; seven areas assess the caregiver and 13 areas assess the child. Each assessment area is assigned a score from one to four (with a score of one being the lowest, meaning that the child and household are severely disadvantaged, and a score of four being the highest, meaning that the child and household are coping relatively well). A child is determined to be eligible if the child receives four scores of one or eight scores of two, or some combination of the two. Volunteers expressed confidence in the validity of the tool, explaining that the CSI "*helps us to verify that we are working with the most vulnerable.*"[12] However, others expressed concerns that assigning a numerical value to vulnerability gave an unrealistic impression of objectivity to a process that is fundamentally subjective. A few criteria automatically qualify a child and household for services: 1) if a child is HIV-

10 Key informant interview, Chief of Party Yekokeb Berhan. September 30, 2015.

11 Federal Democratic Republic of Ethiopia, Ministry of Women, Children and Youth Affairs and Federal HIV and AIDS Prevention and Control Office (2010). Standard Service Delivery Guidelines for Orphans and Vulnerable Chidlren's Care and Support Programs

12 MEASURE Evaluation (2013). Research on the original Child Status Index has shown that it is too subjective to be an effective assessment or targeting tool. http://www.cpc.unc.edu/measure/resources/publications/sr-12-68

positive and not enrolled in treatment, 2) if a child is known to be (or appears to be) abused or exploited, and 3) if a child is moderately or severely malnourished.[13] The assessment process takes about a day or two, and is submitted to the CCC/CC office for review. Within a week or two the assessment is approved, and the case plan is initiated.

The Child Support Index is based on the Child Status Index,[14] but with a few key adaptations. The Child Status Index includes additional indicators, for example to assess disability, HIV-status, economic security, and coordination of care. It also fosters child and adolescent engagement in the assessment process. In addition, it recognizes the relationship between the well-being of the household and the well-being of the children living in the household. For this reason, the Child Status Index assesses the well-being of an entire household rather than focusing exclusively on the well-being of individual children. Finally, the Child Support Index also uses drawings and symbols that are familiar to and representative of Ethiopian culture and practices. The pictures make the tool easy to use for low-literacy volunteers.[15] Volunteers appreciate that the tool is easy to understand, and indicate that the pictures associated with the questions help them to engage children and caregivers: "*The CSI questions for children are easy to use. Pictures help. We were also trained to unpack the questions in a child-friendly manner. The children trust us and so they tell us. We listen.*"

DEVELOPMENT OF A CARE PLAN

In the third year of programming, Yekokeb Berhan staff revised the CSI to add a small space below each indicator to include care plan details during the assessment process. The merging of the assessment and care planning process was considered helpful by volunteers, and enabled them to save time completing these critical steps in the case management process. The CSI form and care plan are updated on a yearly basis.[16] The CSI is central to the case management process as it includes information related to the strengths and needs of the child, referrals to services, and follow-up. However, the care plan remains minimal in terms of narrative, and does not include goal setting by the project participant (child or caregiver).

Fifteen interrelated indicators are covered in the vulnerability analysis, and include:

- Shelter safe and dry
- Primary caregiver is 18 or older and provides regular care, attention, support
- Household has access to safe drinking water
- Household is able to meet minimum needs (expenses) most of the year
- Family has regular income and/or assets
- Child has access to health care services, including preventive and curative
- Child has locally available food on a regular and consistent basis
- Child (7+) attends school, is performing well, and graduates to next class
- Child has sufficient school materials, supplies, and school clothes
- Child appears safe from any abuse, neglect, or exploitation
- Child is sociable and enjoys playing with peers

Scores for these indicators are averaged, and based on those scores, households are categorized into three types: "destitute," "struggling," or "growing." Findings from the assessment are used to inform the care plan. For example, if scores from the CSI categorize a household as "struggling," the care plan will include interventions to improve money management (e.g., enrollment in a savings and loan association). The economic strengthening interventions outlined in the household care plan reflect approaches outlined in the 2012 PEPFAR Guidance for OVC Programming, which promote the practice of selecting economic strengthening interventions that best meet the needs and maximize the resources of each individual household.[17] These measures are reassessed each year in the hopes that economic interventions enable households to be recategorized as less economically vulnerable (e.g., move from the "destitute" category to the "struggling" category, and eventually to the "growing" category).

ENROLLMENT

Once the CSI is complete, the volunteer presents the findings from the assessment and care plan to the CCC/CC to determine a child's eligibility for Yekokeb Berhan's care and support. The CCC then verifies the assessment: "*They do this because they have had training on the CSI and how to score it. Sometimes they go to the individual beneficiaries' homes to confirm that what is in the CSI is true. They want to be sure because they are responsible for giving final approval.*" When the CCC is confident that the information provided is correct and the children and households meet eligibility criteria, they are then enrolled in the project, their CSI results are uploaded to the project database, and their case file is created and stored at the CCC office within a locked cabinet to ensure confidentiality. The caseworker can access the file when needed – though some acknowledged that they did not review information in the files as frequently as they should, and generally only tracked progress against care plans during reassessments. The CCC review and approval process typically takes between one to two weeks to complete. This process

13 Yekokeb Berhan Implementation Guide for Partners.

14 MEASURE Evaluation (n.d.). The Child Status Index provides a framework for identifying the needs of children and creating an individualized, goal directed care plan. http://www.cpc.unc.edu/measure/resources/tools/child-health/child-status-index

15 Yekokeb Berhan Child Support Index, http://www.ovcwellbeing.org/wp-content/uploads/2014/05/CSI-and-Care-Plan-Tool.pdf; Child Support Index Scoring Guide and Codes, http://www.ovcwellbeing.org/wp-content/uploads/2014/05/Child-Support-Index-Handout-copy.pdf

16 Yekokeb Berhan Child Support Index, http://www.ovcwellbeing.org/wp-content/uploads/2014/05/CSI-and-Care-Plan-Tool.pdf; Child Support Index Scoring Guide and Codes, http://www.ovcwellbeing.org/wp-content/uploads/2014/05/Child-Support-Index-Handout-copy.pdf

17 PEPFAR: The U.S. President's Emergency Plan for AIDS Relief. (2012). Guidance for orphans and vulnerable children programming. http://www.pepfar.gov/documents/organization/195702.pdf

is designed to facilitate engagement and ownership of the care plan by community stakeholders. However, given that the members of the CCC are government representatives and community leaders, facilitating them to gather together at specific times and places can be challenging, and the approval process is sometimes delayed. In addition, some community volunteers indicated that the entire process of assessing children and households, developing care plans, and then verifying the assessments and care plans could be lengthy, as well as awkward if, after such a thorough process, children and households were not approved for enrollment.

SERVICE DELIVERY

Pact's partners provide a range of direct services to children and caregivers, as well as refer them to services not offered by the Yekokeb Berhan program. The services provided directly by the program are usually provided within one week to one month after referral and include health care, food and nutrition (including permagardening), education (including early childhood development), shelter and care (including parenting skills building), legal protection in response to violence, psychosocial support (including different training, such as life skills for adolescents), and household economic strengthening. The program uses a variety of technical resources to support training and service delivery. Most of the programs/resources were adapted from other programs in Ethiopia or the region (for example, the life skills training course was developed by a former OVC project in Ethiopia, and the Journey of Life psychosocial resource was developed by the Regional Psychosocial Support Initiative [REPSSI] in southern Africa). However, some resources were developed directly by the program to address unique demands. For services that Yekokeb Berhan does not provide directly, referrals are made to other service providers in the community. For example, children who present as malnourished are often referred to the World Food Program for food assistance.

When making referrals to services not provided by Yekokeb Berhan, CCCs/CCs function as a referral "hub," or serve in the role of referral facilitator. Since a CCC is structured to include representatives from a range of sectors – including government programs (such as education, health, and child protection services), faith-based organizations, civil society organizations (such as women's and adolescents' groups) – CCC/CC members are very familiar with service providers and services available in their communities. At the beginning of the project, Yekokeb Berhan supported each CCC/CC to conduct a service mapping exercise to identify available service providers in their communities. The resulting service directories and service maps are updated routinely to ensure that new providers are included. As one CCC member stated, "*We have a service map, so we know where to knock*." Having the CCC actively engaged in this step of the case management process promotes ownership and accountability for the referral, and helps to promote multi-sectoral engagement and referrals to services that might be unknown or not typically considered under a single-sector approach. According to Yekokeb Berhan management, program participants typically access a referred service in two weeks, but referrals can sometimes take several months to complete.

Case conferences are a regular practice that foster collaboration and promote sharing.

Photo by David Snyder for CRS

In addition to service mapping, the CCCs/CCs also negotiate with service providers to expedite delivery of specific critical services, such as HIV testing and counseling, education, or child protection. They sign a Memorandum of Understanding (MOU) with service providers to outline processes for managing referrals, and Yekokeb Berhan has developed tools and resources to facilitate these processes. For example, when a child is in need of a service not provided by the project, the community volunteer completes a referral form, and provides the referral from to the CCC/CC for review and approval. It is the responsibility of the CCC/CC to manage the referral, and to ensure the child and caregiver access the service. This is done in a variety of ways. For example, a member of the CCC/CC may give the child and caregiver an official referral slip, a formal letter of introduction, or personally make a phone call or in-person visit to the service provider to introduce the child and caregiver. Although the support provided by Yekokeb Berhan to strengthen referral mechanisms has improved these processes, many service providers are overwhelmed and unable to meet the needs of those referred to them for assistance. In communities where a CCC exists and is mandated with coordination, managing bi-directional referrals between Yekokeb Berhan and other service providers, particularly health facilities, is more successful. In communities where the CC is not legally recognized, the success of referrals has depended on the willingness and interest of children and caregivers referred from health facilities to Yekokeb Berhan to be managed by the CC.

MONITORING

Progress toward achieving goals and objectives outlined in care plans is monitored through a range of methods, such as case conferences and joint home visits. Case conferences regularly bring together volunteers, local IP staff, and CCC/CC members to review cases, problem solve, and identify priority actions. Case conferencing was recognized as a helpful way to foster collaboration between volunteers and the CCC/CC and promote sharing of information, as well as to provide supportive supervision to volunteers. Volunteers typically

conduct home visits once a week, and have a caseload of 25 households. Furthermore, joint visits by volunteers, IP staff, and/or CCC/CC members to clients' homes are also regularly conducted to verify information in the case files collected by the volunteers. Many volunteers expressed appreciation for the joint visits, indicating that visits fostered a team approach. They were proud to share the work that they had accomplished in coordination with the household. The community facilitator conducts joint home visits with a different volunteer each week. This is done in an effort to provide supervision, and ensure that home visitations are happening in a correct manner that reflects good practice. The government conducts joint visits on a quarterly basis, typically with the implementing partner, the community facilitator, and the volunteer.

During their initial training, community volunteers are trained on how to communicate with children. The volunteer is made aware of the delicate balance between finding a "private" space to engage the child in a conversation without going too far away from the child's caregiver. The child's safety and comfort are prioritized. The training package for a community volunteer is time intensive, and covers a wide range of issues that volunteers may face in the course of working with highly vulnerable children and their families. Volunteers can complete all of the Basic Volunteer Training modules at once by attending a full-time training over five-and-a-half days, or complete one or two modules a week at a time over several weeks. However the facilitator decides to conduct the training, volunteers must finish the Basic Volunteer Training within the first six months of their service. Regular refresher trainings are also held on an annual basis.

Different types of monitoring and reporting tools are used by different people at different times to monitor different activities during the case management process, but the CSI is the primary tool for enrollment, care planning, and monitoring. Community facilitators oversee approximately 30-35 community volunteers. They meet with volunteers on a weekly basis to offer supportive supervision, in-service training on specific topics, or to collect reporting forms from household monitoring visits.

Volunteers conduct weekly household monitoring visits using a simple reporting form on which they write notes about the well-being of the children and caregivers within their caseload. The reporting form allows volunteers to update each household's care plan, if needed, although volunteers acknowledged that care plans are rarely adjusted until more comprehensive reassessments are completed each year. Community volunteers use the CSI to carry out reassessments. The CSI is also used to determine readiness to graduate. Although community volunteers believed that using the CSI to assess eligibility for enrollment, develop care plans, and assess readiness to graduate created a simple and transparent process for making difficult decisions, some acknowledged that that indicators for eligibility enrollment were not necessarily appropriate for assessing readiness to graduate. For example, some believed that criteria for graduation should be more rigorous and reflect the achievement of project objectives and improvements in OVC well-being.

Once a child has achieved a degree of self-sufficiency, he or she is exited from the program.

Photo by Debbie DeVoe/CRS

CASE CLOSURE

Yekokeb Berhan defines *graduation as the end goal that we work toward.* The concept of graduation, commonly used within poverty reduction programming, is also referred to within OVC programming as case plan achievement. Case plan achievement is broadly understood as the point at which a child and family are able to meet their basic needs and the predetermined benchmarks in the areas of safety, stability, education, and health, and no longer require the interventions offered by an OVC program. Because Yekokeb Berhan described this process as graduation rather than case plan achievement during the implementation of this project, the term graduation is used throughout this case study.

Within Yekokeb Berhan, children rather than households graduate. Because the program is *child centered and family focused*, the household cannot graduate until all children within the household are ready to graduate. A child's readiness to graduate is assessed through a review of the results of the child's CSI assessments conducted throughout the program, and a final assessment of the economic stability of the household. A child is determined to be ready to graduate when his/her score has improved to the level of 3s and 4s, indicating he/she is no longer highly vulnerable. Within Yekokeb Berhan, graduation refers both to those children and households that have achieved a degree of self-sufficiency and no longer require direct support, as well as children and households who have exited the program for other reasons. For example, a child is eligible for graduation from Yekokeb Berhan when one or more of the following criteria are met:

1. Parents or guardian of the child opt out (refuse to participate in the program any longer).

2. Child is receiving similar or equivalent services from another organization or program.

3. Child has reached age 18.

4. Child is doing relatively well, as determined by the Child Support Index.
5. Child's emergency needs have been successfully addressed, and otherwise, the child is not eligible.

The program also refers to children who have been lost to attrition (e.g., children who have moved away and can no longer be located by the program), and children who have been transferred to other programs as having graduated.

The wide range of criteria for graduation has created some confusion and misinterpretation of program results. For example, some children may exit the program, but still experience vulnerability. However, a child is not eligible for graduation from Yekokeb Berhan if he or she is living with HIV, malnourished, or experiencing abuse.

Yekokeb Berhan staff begin working with a child and caregiver to plan for graduation from the point at which the child and caregiver are first assessed. Resources are scarce, and the program is not designed to provide long-term services. Building the capacity of children to care for themselves, and building the capacity of caregivers and their communities to better care for children enrolled in the program is critical. Graduating children from the program creates opportunities for other more acutely vulnerable children and families to receive program support.[18]

Although Yekokeb Berhan would prefer to support all children and caregivers to achieve a level of self-sufficiency and *graduate from the project prior to project closing*, some of the children and caregivers enrolled in Yekokeb Berhan need to be "transitioned" to other sources of support. Currently, OVC programs refer to the shifting of cases from one program to another program as the "transfer" of cases. Because the Yekokeb Berhan described this process as transition rather than transfer during the implementation of this project, the term transfer is used throughout this case study.

When Yekokeb Berhan was required to shift programming to regions with higher HIV prevalence and close down programming in regions with lower HIV prevalence, Yekokeb Berhan developed transition plans for children and households living in regions with lower HIV prevalence and transferred to these cases to other service providers. Yekokeb Berhan staff developed a Beneficiary (Child) Transitioning Guide to help staff to develop transition plans in consultation with the child and caregiver prior to the withdrawal of direct project support. The transition plan outlines the final set of services that the program will provide to help the child and household achieve self-sufficiency or access ongoing support through another service provider. Transition plans are also developed for children "graduating" which again has resulted in the conflation of different processes. Transition plans may include:

- Life skills training for children approaching age 18 (16+);
- Counseling/sensitization for children and caregivers to prepare for the transition;
- Referral to other service providers for ongoing support;
- Ongoing provision of need-based support through resources mobilized by the CCC;
- Home visits, follow-up meetings with the child and caregiver.

Similarly, Yekokeb Berhan worked closely with kebele, woreda, and regional government structures to develop a programmatic transition plan. It is generally expected that the transition plan will be developed and implemented within a six month-period, although a longer transition may be allowed where the implementing partner documents a concern that might result in increased vulnerability for the child. For example, if a child will not be able to complete his/her education within a six-month period, but might finish with a few additional months of support, the transition plan can be extended. Once the transition plan is complete, the project closes the case file, and staff are able to enroll additional children and households in consultation with the CCCs/CCs.[19]

DATA COLLECTION, STORAGE AND USE

Data use. When Yekokeb Berhan began, staff described government partners and local IPs as unaccustomed to regular data collection and analysis. They were unfamiliar with using data to design and revise interventions. To address this lack of experience, Yekokeb Berhan was required to build clear and user-friendly data collection and analysis protocols. However, over time and with practice, these tasks became more routine and in some cases, partners have begun to demand additional data to inform decision-making processes. A member of Pact noted, *"This was very difficult in the beginning. It felt like we were constantly pushing the IPs. There was not an understanding of how data could help them. After a while, it was the IPs pushing us for data as they realized how much it helped them and the program."*[20]

Data collection. Yekokeb Berhan has established its own Operational Guidelines for the purpose of Monitoring, Evaluation, Reporting and Learning (MERL), including guidelines for data collection and analysis at all levels of the case management system. MERL guidelines include instructions for data management, ensuring data quality, and monitoring processes, and outline documentation required from all IPs. The guidelines also include data collection forms that feed into the MERL system. The program has acknowledged some data challenges specifically in the area of data quality, transcription, and the documentation of proper service codes.

Data storage. Yekokeb Berhan case files are stored at the CCC/CC office in each community in order to foster ownership of the case management system by the CCC. In communities without CCC offices, case files are stored within a local implementing partner office. A volunteer explained, *"Ultimately the CCC is the owner of the documents and this "forces" them to be engaged in the process."* Volunteers

18 Pact/Yekokeb Berhan: Criteria for Transitioning out of the Program ("Graduation").
19 Pact/Yekokeb Berhan: Beneficiary (Child) Transitioning Guide.
20 Key informant interview with Pact, Addis Ababa.

reported that storing the case files at the CCC/CC office made them more accessible to volunteers, as the local IPs were frequently located a distance from the community. Having a safe place to store files also promoted confidentiality.

Conclusion: Coordinating care and strengthening sustainable systems

Yekokeb Berhan has intentionally designed all aspects of the program to link with, build upon, and strengthen existing community structures and government systems. This intentional approach to system strengthening has resulted in government engagement and ownership of case management. Utilizing the roll out of the National Social Protection Policy which envisaged the establishment of CCCs at kebele and woreda level, Yekokeb Berhan was able to integrate the CCC into the coordinated care approach, ensuring that government took responsibility for the provision of services and management of individual cases involving vulnerable children and families. Beginning with joint trainings, case conferencing, and coordinated monitoring and supervision, the CCCs have played a pivotal role in the success of the case management process. Although local implementing partners play a key role within the program, the value of working toward and fostering government ownership to eventually take on this responsibility is understood by all. According to a local government official, *We are like two sides of the same coin. They trust us and we trust them. We know that if we have a problem they will help us.*

When Yekokeb Berhan comes to an end, the case management system and files will remain intact, housed in each CCC office with representatives who are actively engaged and committed to the care and well-being of the enrolled child. In the words of a volunteer, *"The difference with Yekokeb Berhan and other projects in the past (and now) is that they did not just come and do things, they built our capacity so that we can do it for ourselves."*

Annexes

Annex 1: Documents reviewed

Icos Consulting PLC. (2015 August). Impact of Yekokeb Berhan Program Economic Strengthening Interventions to Improve Livelihoods of Households Caring for Highly Vulnerable Children (final report).

Yekokeb Berhan Newsletter, Issue Number 6 (June 2015).

Yekokeb Berhan Program (May 2015). Beneficiary (Child) Transitioning Guide.

Yekokeb Berhan Program (December 2013). Child Support Index & Care Plan Training for Partners and Volunteers: Facilitator's Manual.

Yekokeb Berhan Program (February 2015). Community Saving Self-help Group Strengthening and Graduation Guide (Revised).

Yekokeb Berhan Program (June 2015). Standard Operational Guidelines for Implementing Partners.

Yekokeb Berhan Program (n.d.). Criteria for Transitioning Out of the Program 'Graduation.

Federal Democratic Republic of Ethiopia, Ministry of Women, Children and Youth Affairs and Federal HIV and AIDS Prevention and Control Office (2010). Standard Service Delivery Guidelines for Orphans and Vulnerable Children's Care and Support Programs

Federal Democratic Republic of Ethiopia (2013). Occupational Standard Community Service Works. NTQF Level I, II, III, IV and V

Yekokeb Berhan Program (2014). Better Parenting Training Job Aid.

Yekokeb Berhan Program (n.d.). Child well-being data management system (cwb-dms) System documentation.

Yekokeb Berhan Program (n.d.). Guidance for managing disclosure of one's HIV status.

Yekokeb Berhan Program (n.d.). Supplemental Guidance on Yekokeb Berhan can better serve HIV- affected children and their families.

Yekokeb Berhan (in draft). Impact of Better Parenting Training on Parenting Attitudes and Practice. Received from author.

Annex 2: List of key informants

NO	NAME	TITLE	ORGANIZATION
1.	Dr. Samson Radeny	COP	Yekokeb Berhan, Pact
2.	Gobena Seboka	DCOP	Yekokeb Berhan, Pact
3.	Abdu Ebrahim	MERL Manager	Yekokeb Berhan, Pact
4.	Thomas Yewhalawork		Yekokeb Berhan, Pact
5.	Medhanit Wube	Technical Director, YB	Yekokeb Berhan, FHI 360
6.	Melesse Yigrem	Technical Director, YB	Yekokeb Berhan, ChildFund
7.	Walelign Meheretu	Senior OVC Program Advisor	USAID Ethiopia
8.	Tsegaye Tilahun	OVC Program Advisor	USAID Ethiopia
9.	Shemelis Fantahugne	Program MERL Officer	ADA
10.	Hamid Ahemed	Program Director	ADA
11.	Tesfaye Shite	Program Project Coordinator	ADA
12.	Zehanarhos Tesfaye	HVC Program Officer	ADA
13.	Sichalew Gelaneh	Yekokeb Berhan Coordinator	ADA
14.	Daugna Atashel	Bahir Dar MERL Officer	ADA
15.	Aliegn Kume	Volunteer/Selection Sub-committee Member	CCC
16.	Segemet Mekonew	Volunteer/Selection Sub-committee Member	CCC
17.	Newmlework Aene	Volunteer/Selection Sub-committee Member	CCC
18.	Ashagoru Ali	Head of CCC	CCC
19.	Emanye Gentu	Volunteer/Selection Sub-committee Member	CCC
20.	Sliselamwit Aberahame	Health Extension Worker	CCC
21.	Emanye Gentu		CCC
22.	Asnake	Community Facilitator	ADA/CCC
23.	Ashagre Zewde	Child Rights, Welfare and Care Process Owner	BOWCYA Bahir Dar
24.	Belete Birara	Child Rights, Welfare and Care Expert	BOWCA Bahir Dar
25.	Getnet Sintayo	Head of Health Center	Health Center, Bahir Dar
26.	Meseret Yimanu	Community Facilitator	ADA, Health Center
27.	Tarike Yohannes	Health Extension Worker	Health Center, Bahir Dar
28.	Aster	Graduated HH, Positive Mother of Selamwit (18)	Home, Bahir Dar
29.	Tewodros Kassahun	Regional Coordinator, Pact	Pact
30.	Mihret Dagnew	MERL Officer, Regional Office	Pact
31.	Sister Tibebe Maco	Executive Director	HIDA
32.	Ephrem Shiferaw	Program Director	HIDA
33.	Meseret Bekele	ES Officer	HIDA
34.	Zelalem Belay	Project Coordinator, YB	HIDA
35.	Yonas Lemma	MERL Expert	HIDA
36.	Wondifraw Tena	Project Officers (Akaki)	HIDA
37.	Getnet Tadesse	Project Officer (Gulele)	HIDA
38.-58.	20 Community volunteers	Beneficiary, Volunteers, CCC Members, and BOWCYA Staff	Akaki Kaliti CCC Woreda 7 BOWCYA

NO	NAME	TITLE	ORGANIZATION
59.	Andualem Tesfaye	Manager	FHIDO
60.	Abraham Tura	Project Coordinator, YB	FHIDO
61.	Desse Awgocjawe	MERL Officer	FHIDO
62.	Wudneh Asrat	Knowledge Mngt and Learning	FHIDO
63.	Fertahun Kolech	ES Officer	FHIDO
64.	Yonas	Program Coordinator	FHIDO
65.	Abera Desaheln	CC Member	Woreda 7
66.	Hasi Mustafa	CC Member	Woreda 7
67.	Hasi Shikur	CC Member	Woreda 7
68.	Tewabech Birlanu	Volunteer	Woreda 7
69.	Sada Yasin	Volunteer	Woreda 7
70.	Abebed Tasew	Volunteer	Woreda 7
71.	Yeshiwork Ayichilumem	Volunteer	Woreda 7
72.	Askalech Baela	Volunteer	Woreda 7
73.	Aregash Hussen	Volunteer	Woreda 7
74.	Tewodros Belay		ESSSWA
75.	Fantahun Gobezie		ESSWA
76.	Belen Mekonnen	Regional Manager	Yekokeb Berhan, Pact

Coordinating Comprehensive Care for Children (4Children) is a five-year (2014-2019), USAID-funded project to improve health and well-being outcomes for Orphans and Vulnerable Children (OVC) affected by HIV and AIDS and other adversities. The project aims to assist OVC by building technical and organizational capacity, strengthening essential components of the social service system, and improving linkages with health and other sectors. The project is implemented through a consortium led by Catholic Relief Services (CRS) with partners IntraHealth International, Pact, Plan International USA, Maestral International, and Westat.