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Coordinating Comprehensive Care for Children

A CASE STUDY HIGHLIGHTING THE RESULTS OF INTEGRATED CHILD PROTECTION AND CARE AND TREATMENT PROGRAMMING IN NAMUTUMBA, UGANDA

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This report is made possible by the generous support of the American people through 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

A growing body of evidence supports the theory that child protection and HIV care and treatment outcomes are inextricably linked. Protecting children from abuse, violence, exploitation and neglect, is essential to achieving an AIDS-free generation, and providing children living with HIV access to HIV testing, treatment and the support necessary to live a healthy and independent life is a critical objective of both child protection and care and treatment programming.[1]

This case study describes the process, methods and results of the approach promoted by World Education's Bantwana Initiative ("Bantwana") under two USAID/PEPFAR funded consortium projects in Uganda: SUNRISE-OVC, a systems strengthening project primed by The International AIDS Alliance partnering with the Ministry of Gender, Labour and Social Development (MGLSD), and STAR- EC, an HIV care and treatment project primed by John Snow International partnering with the Ministry of Health (MoH). The case study focuses on a) the steps Bantwana took to integrate these two projects, b) the development of a Ugandan case management system through collaborative engagement with both projects, and c) the initial results of integrating the projects, measurable changes in outreach to vulnerable children and pediatric enrollment in care and treatment, and d) the potential for this approach to impact child outcomes.

These findings were compiled during a portfolio review of OVC programming in Uganda and final evaluation of the SUNRISE-OVC Project carried out by 4Children, through interviews with Bantwana leadership (the country director and head of programs), SUNRISE-OVC and STAR-EC staff, and district government officials in Namutumba, Uganda.[2] As the portfolio review proceeded, it was clear that Bantwana's decision to integrate its programs had yielded improvements in vulnerable children's access to services.

Parallel Programming

Bantwana began working in Western Uganda in 2008[3] and in East Central Uganda in 2009 as an implementing partner on the USAID/PEPFAR STAR-EC project across nine districts with high HIV prevalence. In 2010 Bantwana joined the USAID SUNRISE-OVC project as a technical service organization (TSO) covering nine east central districts, six of which overlapped with STAR-EC. From the outset, STAR-EC and SUNRISE-OVC worked with two different Ministries, had distinct objectives and approaches, and different consortium leadership. STAR-EC was designed to increase coverage and utilization of quality, comprehensive HIV&AIDS and tuberculosis prevention, and care and treatment services. SUNRISE-OVC was designed to strengthen the local government social welfare system, building the government capacity to coordinate the child protection and OVC response. The two projects each worked with community volunteers,

[1] Long, S and Bunkers L. (2013) Building protection and resilience: synergies for child protection systems and children affected by HIV and AIDS. For the IATT on Children and HIV and AIDS

[2] The 4Children team did not conduct a formal evaluation of the STAR-EC project, but met with STAR-EC staff during the portfolio review and development of the case study.

[3] Under the Western Uganda Bantwana Program (WUBP 2007 -2013), Bantwana used an integrated economic strengthening, child protection and psychosocial support (PSS) package to support 5,000 highly vulnerable children and families and established a referrals and linkages service delivery model which formed the basis for the integrated models expanded by Bantwana under STAR-EC.

but the SUNRISE para-social workers (PSW) provided support at the parish level, conducting home visits and acting as a local liaison to the social welfare office with a child protection mandate, and STAR-EC village health teams (VHTs) and expert clients operated at the village level, conducting home visits and acting as a local liaison to the health facilities. At the parish and village level, some volunteers act as both PSWs and members of the village health teams. An overview of the Uganda administrative divisions, key child protection actors and coordinating bodies is provided in Annex I.

Three years into the project, just after the midterm evaluation, the Namutumba District was struggling to meet the targets of the SUNRISE-OVC project and staff had identified gaps in the social service strengthening approach.

> *We were performing poorly–our results indicated there were problems. District OVC Committees (DOVCCs) didn't have appointments, strategic plans were not passed yet, and meetings were not consistent. At District, Sub-county level, the Community Development Officer (CDO) would not show you homes they have visited.* (KII, SUNRISE OVC Officer)

STAR-EC program staff identified similar delivery challenges: according to their OVC Project Manager, in some cases less than 45% of referred patients reached their next service point, and there was no mechanism to ensure referrals were followed or to ascertain the number of referred individuals who received services following referral. As of 2012, enrollment and retention of pediatric cases was low (5-6%), compared to the UNAIDS estimate of 15 % pediatric HIV prevalence.

Reflecting on these issues, Bantwana leadership recognized that although the project structures and objectives were different, the goals were the same: to improve the well-being of all children, and by more effectively connecting and leveraging the work of the two projects, there might be an opportunity to increase their impact.

> *STAR-EC is looking for the same children as SUNRISE. If you're going to have a lasting intervention, you have to have OVC and HIV together. We were lucky. We were participating in both OVC and HIV Care and Treatment programs. USAID asks STAR-EC about OVC, and when they reached SUNRISE, USAID asks about care and treatment.* (KII, Senior Leadership, Bantwana Initiative)

The Decision to Integrate

In 2013, just over midway through implementation of the STAR-EC and SUNRISE projects, and with a recently launched Youth Empowerment Project added to their portfolio, the Bantwana country program in Uganda made the decision to integrate their HIV Care and Treatment and OVC programs, transitioning from being project focused, managing three distinct projects, to an integrated approach focused on child-outcomes. Bantwana invited staff to come together and identify the gaps in the system making it difficult for children to access services, and propose

solutions, finding support to pilot the proposed changes to the system where needed.

Staff reported that the integration process was challenging in the beginning as the team needed to identify a common language and build relationships between staff managing large projects in different sectors. In initial stages of OVC integration, the STAR-EC staff would not approve any activity that involved social welfare staff such as the Community Development Officer (CDO), or a member of the Child Protection Committee (CPC) as social welfare staff were not recognized under the health system.

> *The language of child protection is not the same language of health – we had to sell it to our own staff. We had to build trust. If you're going to work with an expert client or Village Health Team (VHT), that is okay, but with community development staff they ask, what are their roles, how do they contribute to their program?* (KII, Senior Leadership, Bantwana Initiative)

Following facilitated discussions between staff from both projects, Bantwana proposed the following changes, testing solutions proposed by staff from both projects to fill perceived gaps in the existing system.

1. ***Integrated staff meetings facilitating sharing and lessons learned****.* Bantwana held regular meetings with all project staff, requesting that each project provide an update on a) what they did last week, b) what they planned to do next week, and c) a lesson learned or insight from the past week's activities. The combination of regular meetings and strategic emphasis on learning and sharing helped staff to identify opportunities for collaboration.

2. ***Task shifting to interns/locums****.* Bantwana hired interns, often recent university graduates, placing an intern at the health center tasked with supporting integration through referrals to the CDO's office, police, or to other CSOs providing support when they identified potential child protection concerns such as neglect and abuse, those needing adherence counseling, psycho-social support or basic care including food, clothing, shelter and education support. Other linkage facilitators were placed at the CDOs office to receive children and their caregivers referred by the health center or other services, and record their details in the Case Management book issued by the Ministry of Gender, Labor and Social Development. Interns would then check the service register, identify the appropriate service provider, make a contact call to ensure the desired service is available and refer or escort the client to the next point of service. The intern then helps to update the registers after confirming feedback that the client got the service.

3. ***Monthly Case Conferences at sub-county level****.* Relevant community-based organizations providing services for OVC and affiliated community actors including PSWs, expert clients, health workers and police officers began to meet once per month to review their case books and discuss challenges, sharing experience across sub-county

parishes.[4] Monthly meetings were typically attended by at least one PSW to share cases identified, referred, monitored/followed-up. The CDO would approve closure of cases once all stakeholders (CCW, police, local council leaders, head of education institutions, VHTs, health workers, etc.) agree that the child is out of danger following a home visit or feedback report from a CCW or CDO, if a service has been provided and the child's needs have been met.[5] This is a component of the Namutumba case management model described below.

Bringing together staff from both social welfare and care and treatment projects created a collaborative and open environment to launch more ambitious initiatives as well. Staff were asked, "*What is that one thing that can bring changes?"* The Bantwana Country Director had experience piloting a case management model in Zimbabwe and asked project staff and community development officers: "*What is the child protection system? Is it working? What are the challenges? What would work here? How can we close the gaps?"* The development of a Uganda-adapted case management model was proposed to address two critical gaps in the system: a) linking community/village level child protection mechanisms to the sub-county and district system and b) creating one mechanism for both health and OVC issues at the community level. With these objectives in mind, the CDOs in Namutumba District, worked closely with Bantwana STAR-EC and SUNRISE-OVC staff to create the Namutumba Case Management Model.

Namutumba Case Management Model

Case Care Workers. Bantwana works with communities to identify experienced community volunteers to be trained to identify, assess, assist, and as needed, refer, children and families in need of child protection services. Case Care Workers (CCW) are expected to be literate and have a demonstrated interest in child protection, and in many cases CCWs are also trained PSWs or members of village health teams. PSWs and CCWs share an overlapping mandate, but the Case Care Workers coordinate the child protection response at the village level as part of the village *child protection committee*. Case Care Workers are trained in case documentation to improve monitoring, coordination and closing of cases with approval of the CDO. They are also provided notebooks and lock boxes to use for case management and referrals as well as contact lists of functional service providers within their catchment area (referral guides/service directory).

Child Protection Committees. Case Care Workers are members of community-level child protection committees that operate under the guidance and leadership of Local Councils, and create direct linkages with district officials through monthly meetings and consultation on child protection committees. CCWs are responsible for tracking and monitor cases and will share reports with their CDOs.[6]

Case conferencing. Case Care Workers from each village meet monthly with other CCWs and the CDO alongside other child protection actors (health workers, local leaders, police, religious leaders, orphanage institutions and school managers) in their sub-county to review open cases, document the types of cases being referred, actions taken and services received. Cases which have been successfully

[4] Case conferencing later became an integral component of the Namutumba Case Management Model, and monthly case conferences are now also attended by community care workers, managing cases at the village level.
[5] Highly vulnerable cases like those involving HIV+ children would be left open indefinitely to help ensure that children and families were able to attend clinic appointments and had adequate adherence support.

resolved by the CCWs are closed by the CDO. Participants are careful not to mention children by name to ensure their privacy is protected to the extent possible.

Follow-up and case closure: Following the case conferencing meetings, an assessment is taken to measure whether the services provided were sufficient to meet the child's need. In some cases, follow up home visits may be recommended. Once it is clear that the well-being of the child has improved, the case is closed by the CDO, who stamps and signs the case. 80% of cases are closed within 2 months, depending on the complexity of the case, and more sensitive or complex cases such as defilement or sexual abuse remain open until the court convicts the offender and HIV+ cases remain open to allow for regular follow-up and adherence support.

Results

As the Bantwana experience shows, effective multi-sector integration, just like systems-strengthening, is a process, starting with regular meetings to share plans, lessons learned and ideas across projects, piloting new initiatives and integrating successful approaches into the larger project. Yet, the introduction of the integrated case management model led to a rapid and impressive increase in OVC service delivery, tripling the number of OVC served between the first and final quarter of 2014**.** It is still difficult for each CDO to reach all households in the sub-county, but they receive support from community case care workers. With more staff collaborating in an integrated system, target numbers are surpassed without struggle.

Table 1: Number of OVC served per district and quarter in 2014[7]

Sub-county	Quarterly targets	No. of OVC served Jan-Mar 2014	No. of OVC served April-June 2014	No. of OVC served July-Sept 2014	No. of OVC served Oct-Dec 2014
Kamuli	2,691	1147	557	2741	3284
Mayuge	2,691	734	1192	2929	2863
Bugiri	2,277	813	1257	2317	2903
Kaliro	1,242	629	577	1550	1430
Namutumba	1,449	675	385	1497	1586
Iganga	3,312	609	872	3549	3871
Total	**13,662**	**4,607**	**4,840**	**14,583**	**15,937**

Number of OVC served was compiled locally by the CDO and DCDO, and submitted to the Ministry of Gender, Labor and Social Development via the electronic OVCMIS system. Services received typically include PSS, education support, health care, HIV care and treatment, and nutrition.

In the 1.5 years since the integration initiative began, Bantwana staff have identified immediate improvements in key indicators for both projects. In the words of one STAR-EC staff: "*It over-turned our results."*

- **STAR-EC increased pediatric enrollment and retention (0-14yrs) from an estimated 4% of population (n=1,719 in 2012) to 7% (n=2,803 in 2014[8])** Staff attribute the increase in

[6] Case Management Toolkit. World Education Inc./Bantwana Initiatives. (2014)

[7] CDOs and PSWOs Case Management books

[8] STAR-EC Program Year 6 Annual Report 2014 pg. 32

pediatric enrollment to a) Intensified HIV testing and counseling in OVC-mapped households with regular follow up visits from CDOs, CCWs and health staff, and b) intensified HIV testing and counseling in fishing communities along landing sites and islands, locations where HIV prevalence is highest. Periodically, a team of health workers together with community-based volunteers trained in HCT visited OVC households mapped by the CDO and conducted home-based HTC. Integrated HCT outreaches to orphanage homes and OVC dwelling places were also done through engaging CDOs and community volunteers in the mobilization of children and caregivers. This increased identification of positive children and caregivers and was followed by an accompanied referral to nearby health facilities for enrollment in care and treatment. CCWs and CDOs then coordinated to conduct follow up visits and provide adherence support, improving enrollment and retention.

- **Social Welfare System improved referral completion between the social welfare office and health system or other CSO from 50% in some settings to 85%[9].** In the initial stages of SUNRISE-OVC, many referrals between the social welfare office and health clinics were not successful. With improved communication networks, health clinic staff were able to inform clients when the CDO would be in his office, and let the CDO when to expect clients. With additional staff, interns and CCWs, children were often accompanied to the social welfare office, health clinic or other service, although funding for transport and long distances between services remain a challenge.

The improved coordination between health facilities, social welfare staff and other local government officials also helped the offices to better collaborate to identify opportunities for vulnerable children and youth to access services and funding and to resolve issues. For example, an HIV positive youth support group formed under STAR-EC worked with the CDO to apply for a funding opportunity under the government's Youth Leadership Program, YLP, to improve their livelihoods, leveraging support across three initiatives. In another sub-county, STAR-EC staff identified high rates of complaints that health workers were charging money to examine victims of defilement (sexual assault of a minor) in spite of a mandate that defilement victims have access to free care. The issue was raised at the next DOVCC meeting with the chief administrative officer (CAO) and health officer, increasing pressure on health workers to comply with the mandate guaranteeing access to treatment for victims of defilement. As a result, there are now fewer complaints and more victims of defilement are able to receive medical care..

As both STAR-EC and SUNRISE-OVC come to a close, Bantwana is looking for future opportunities to continue integrated child protection and care and treatment programming.

> *We have tried to make sure that all upcoming projects are using the same structures, the same cadres of community workers. For all our projects, for instance, we are mainstreaming child protection committees.* (KII, Senior Leadership, Bantwana Initiative)

[9] 15% unsuccessful referrals are the result of transport challenges, procrastination by caregivers, delayed follow up visits, fear of HIV stigma among caregivers and young positives and limited reliable service providers.

Annex I: Local Administration in Uganda and Key Child Protection Actors and Coordination Mechanisms

Administrative level	Key OVC/Child Protection actors	Coordinating bodies
Village is the most local administrative unit in Uganda typically composed of 50-70 households and between 250-1,000 people. Each village will be run by a local council – local council I (LCI) - and is governed by a chairman (LCI chairman) and nine other executive committee members.	***Case Care Workers:***[10] Frontline child protection officers at the village level, drawn from existing volunteer cadres: para-social workers, village health teams and other adults committed to children's safety. They are trained on the basics of case management including: child protection, case identification and categorization, referral, follow-up and case conferencing.	***Child Protection Committees*** operate under the leadership of Local Councils in each village, including case care workers, the village chief and three other committed local leaders. The committees are intended to support case care workers to reduce the burden of an already overstretched social welfare staff at the sub-county and district level, with staff trained to 'close' cases where feasible at the village level, and jointly determine which cases require district involvement.
Parish is the next administrative level up from the village. A parish is made up of around 6-10 villages. Each parish has a local council II (LCII) committee, made up of all the chairman from the village LCIs in the parish.	**Para-Social Workers (PSW):** Frontline child protection officers at the parish level, drawn from existing volunteer cadres: village health teams or community development committees. They are trained on child protection, child rights, documentation and data collection and report to the sub-county Community Development Officer	
Sub-Counties are made up of a number of parishes (~6), the sub-county is run by the sub-county chief on the technical side and by an elected local council III (LCIII) chairman and his/her executive committee. The sub-county also has an LCIII council, consisting of elected councilors representing the parishes, other government officials involved in health, development and education, and NGO officials in the sub-county.	**Community Development Officer (CDO):** Manages OVC and child protection cases, supporting and managing PSWs in the sub-county, providing referrals to the judicial and health systems and civil society organizations for individual children, and working with the Sub-County OVC Committee and District Officials to coordinate the broader response. ***Health and Social Welfare Interns:*** Interns are assigned to health clinics and Social Welfare offices to assist the clinical staff and CDO with case management and referrals.	**Sub-County OVC Committee (SOVCC):** Coordinates cross-sectoral OVC response at the Sub-County level, bringing in education, health, agriculture, planning and other District Officials to discuss OVC concerns and identify solutions. ***Case Conferencing***: CCWs from each participating village in the sub-county meet monthly with the CDO to discuss cases, share experiences and identify solutions to resolve individual cases and broader concerns.

[10] Key child protection actors and coordinating bodies in italics were introduced by Bantwana WEI to support coordination between the health and social welfare system.

Counties are made up of Several sub-counties make-up a county and sub-county executive members make up Local Council IV (LCIV), but these committees have limited powers, except in municipalities.	Not applicable.	Not applicable.
Districts are made up of one or more counties and any municipalities in that area, and may include a population of 500,000 or more. A district is led by an elected local council V (LCV) chairman and his executive and an elected LCV council, with representatives from the sub-counties and technical staff in the district. The council debates budgets, decisions and bylaws. On the technical side, the district is led by a chief administrative officer, appointed by central government. The district government also includes the heads of various departments such as education, health, environment and planning, which are responsible for relevant matters in the whole of the district. At present, Uganda has 111 districts.	**Senior Probation and Social Welfare Officer (PSWO):** A member community-based services department, responsible for improvement of the welfare and rights of children, their protection and development. They are trained to assist victims of sexual abuse to obtain medical examination reports and to have evidence required in court, provide initial counselling to child victims and the family so as to cope with abuse and to also ensure that the child is protected from any form of abuse. **District Community Development Officer (DCDO):** Manages OVC and child protection cases at the District level, providing referrals to the judicial and health systems and civil society organizations for individual children, and working with the Sub-County OVC Committee and District Officials to coordinate the broader OVC response.	**District OVC Committee (DOVCC):** Coordinates cross-sectoral OVC response at the District level, bringing in education, health, agriculture, planning and other District Officials to discuss OVC concerns and identify solutions.