Tanzania

MEASURE Evaluation • March 2019

The Cost of Case Management in Orphans and Vulnerable Children Programs: Findings from Tanzania

INTRODUCTION

Interventions for orphans and vulnerable children (OVC) are socioeconomically driven, community-based services for children under age 18 who have lost one or both parents to AIDS (United States President's Emergency Plan for AIDS Relief [PEPFAR], 2012). OVC programs aim to improve children's resilience to meet their basic needs of health, safety, stability, and schooling, by providing such services as case management, psychosocial support, early childhood development, and household economic strengthening. The end goal of OVC programming is to reduce vulnerability to HIV and AIDS, contribute to HIV prevention, and bolster access to and retention in treatment among children in high-prevalence communities (PEPFAR, 2015).

Little is known about how much it costs to implement these OVC intervention services. When cost estimate data are available, ranges for unit expenditures are strikingly wide, and comparisons across programs or intervention service areas are difficult (Santa-Ana-Tellez, DeMaria, & Galárraga, 2011). The United States Agency for International Development (USAID)- and PEPFAR-funded MEASURE Evaluation project conducted a six-country study for insight on current approaches to case management delivery and the cost of those approaches. The study also explored the context of caseworker (CW) experiences, to inform the cost data. The study was guided by the Coordinating Comprehensive Care for Children (4Children) definition of case management, which encompasses the case management process from start to finish: identification, enrollment, assessment, case plan development, case plan implementation, monitoring, and case closure (Catholic Relief Services, 2017).

PROGRAM CONTEXT

This brief outlines the findings from the Kizazi Kipya project, in Tanzania, which Pact implements in collaboration with five partners and 48 civil society organizations (CSOs). The project, which is funded by USAID, covers all regions of the country and is expected to run from October 2016 to September 2021. Its case management approach is closely aligned with the 4Children process. Beneficiaries are identified through (1) carryover from the past project phase, (2) referrals from HIV care and treatment centers, or (3) through CWs. Case management training was done by a collaborating project implemented by John Snow, Inc. (JSI). The training started at the national level, engaging government stakeholders in the training-of-trainers process before being cascaded to the CSOs and CWs.

The CWs are responsible for following up with potential beneficiaries to conduct screening and enrollment. If a CW finds that an individual or household is eligible, the enrolled family is added to that CW's caseload. Assessment takes place directly following enrollment. A care plan is developed after the first assessment, to determine what services are needed. The care plan implementation step also involves referrals, follow-up, and regular service delivery, which take place during home visits. Follow-up assessments are supposed to be conducted every three months; they are then used to update the care plan. CW activities are monitored and supervised by CSO staff. A care plan is considered "achieved" when it has fulfilled a set of criteria. At that point, a six-month "hold" period is required before beneficiaries may exit the project.

METHODS

Data collection took place from September 18, 2017 to September 29, 2017 in Dar es Salaam and Moshi, Tanzania. Retrospective financial costs and beneficiary data were collected simultaneously with the implementation of in-depth qualitative interviews with project staff and CWs. Staff self-reported the

level of effort (LOE) that they spent on case management. The interviews explored a wide range of experiences related to case management delivery, capacity, and quality. The case management themes that emerged revolved around training, caseloads, compensation, and perceived quality.

RESULTS

Mapping the Program Structure and Government Involvement

The Kizazi Kipya project has direct government involvement; local government participates in CW selection and training processes and works at higher levels on systems change. Information is reported through five levels of staffing: the national office, cluster offices, CSO offices, field offices, lead caseworkers (LCWs), and CWs. The OVC program is delivered and managed either through direct or indirect supervision. The supervision cascade monitors field-level case management delivery by CWs. Staff at the national level are involved in the development of standard operating procedures (SOPs) and supportive administrative activities. Case management technical support officers at the cluster-office level assist the supportive supervision that informs service delivery at the field level. Case management coordinators (CMCs) directly supervise the CWs. Case management officers provide indirect supervision of CWs, supporting the CMCs. LCWs provide additional direct supervision of the CWs and act as CWs themselves, conducting home visits. Figure 1 presents the supervision cascade.

Caseworker Attributes

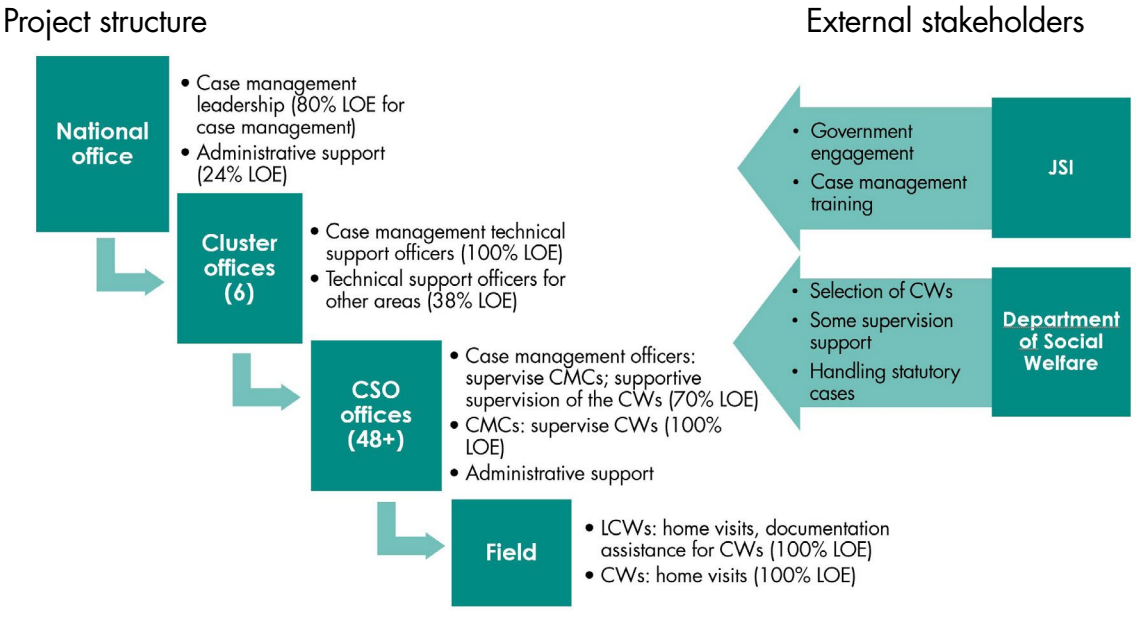
The Kizazi Kipya CWs manage an average of 18.1 households (ranging from 5 to 40 households), with an estimated caseload of approximately 39.2 beneficiaries (Table 1). The CWs fall into two categories: LCWs and CWs. The Department of Social Welfare recruits both, with the goal of one LCW per village to supervise the other CWs. Recruitment involves stakeholder engagement meetings at the county, ward, and community levels. Applicants are interviewed and selected if they come from the village, are below age 55, and are able to read and write. Most CWs have completed primary or secondary school and can read and write. The CWs and LCWs are paid a small stipend, contingent on the completion of their home visits and paperwork. Table 1 presents basic attributes of the 13 CWs/LCWs and 3 CMCs interviewed. The supervisor ratio of 88.7 CWs to one CMC is the highest average ratio found across six projects. In one region, a single supervisor reported working with 108 CWs. The intermediary supervision role of the LCW may offset the burden reported by supervisors. Compensation of CWs and LCWs was reported at about $22 USD per month, with out-of-pocket expenses equaling nearly half that amount ($9.93).

Table 1. Attributes of case management staff

	Caseworkers (n=13)	Case management coordinators (n=3)
Pay (monthly)	Stipend $21.70	Not applicable
Out-of-pocket expenses (monthly)*	$9.93	$38.91
Education Level		
Primary (1–7 years)	5	0
J. secondary (8–9)	0	0
Secondary (10–12)	5	0
Certificate/Assoc.	3	0
Bachelors	0	3
Households	18.1 (range: 5–40)	870
Beneficiaries	39.2 OVC	1800 (est.)
Supervisor ratio	Not applicable	88.7 CWs (range: 78–108)
Experience	1.1 years	0.4 years
Travel time	3.4 hours per week	Not reported

*Out-of-pocket expenses were in addition to monthly pay, which included salary and transportation allowances.

Figure 1. Kizazi Kipya project case management supervision cascade



Cost of Case Management

The total cost of case management for the one year of the Kizazi Kipya project studied—approximately $7.9 million— was the most expensive of all projects examined. With 493,734 caregivers and OVC served by the project during this time, the cost per beneficiary comes to $15.97. This low cost per beneficiary and the high annual cost were primarily because of the scale of the project—the largest of the six projects studied, in terms of beneficiaries reached. This cost does not account for the opportunity cost of government staff time spent on training and CW selection or any out-of-pocket expenses incurred by project staff or CWs.

Training accounted for the largest proportion of the costs (56.8%), because of the large-scale pre-service training implemented during the first year both by Pact and JSI. These training costs were linked to the high proportion of total project expenditures contributing to case management (41%). Another cost driver was CW support (14.0%), which reflects the large relative cost of CW stipends dispersed at the CSO level. The project had a notably low proportion of spending on supervision (5.1%) and monitoring and evaluation (0.4%), and moderate spending on general personnel (11.9%) and office support (6.3%) attributable to case management. The most striking aspect of the cost breakdown is the high investment in training costs coming from JSI. Table 2 provides a summary of the subcategories in each cost category.

Figure 2. Case management cost breakdown

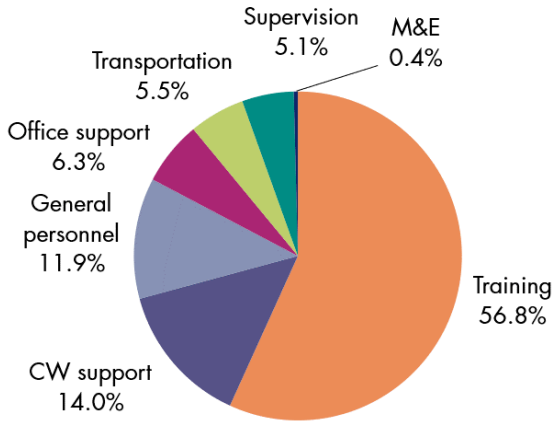


Table 2. Breakdown of costs attributed to case management, by categories and subcategories

Expenditure category	Pact HQ	JSI	Pact CBOs	Total	%
Supervision				**$ 401,097**	**5.1%**
Direct supervision			$ 123,596		
Supervision cascade	$ 131,270		$ 146,231		
Case management & related training				**$ 4,482,213**	**56.8%**
CW training		$ 3,608,149	$ 212,786		
Staff training	$ 49,773	$ 154,528	$ 319,178		
Training support	$ 116,138	$ 21,661			
Travel/transportation				**$ 432,646**	**5.5%**
Field staff and CWs			$ 94,952		
Other travel/supervision cascade	$ 229,824		$ 107,871		
Case management & CW support				**$ 1,103,369**	**14.0%**
CW stipends and materials			$ 782,850		
Printing of tools	$ 25,082	$ 104,968	$ 67,296		
Monthly meeting costs			$ 3,134		
CW identification costs		$ 73,872			
Beneficiary identification costs			$ 8,631		
Communication costs			$ 37,537		
Other costs				**$ 1,466,989**	**18.6%**
Monitoring and evaluation support			$ 33,942	0.4%	
Labor and personnel general	$ 465,901		$ 243,719	11.9%	
Office support	$ 195,030		$ 529,773	6.3%	
Total cost of case management				**$ 7,886,315**	
Annual cost of case management (1 year)				**$ 7,886,315**	
Cost per beneficiary				**$ 15.97**	
Proportion of total project costs spent on case management				**41.1%**	

Children in a classroom at Kamunyonge Primary School during a school bed net distribution event in Musoma, Tanzania. Photo: © 2016 Riccardo Gangale/USAID, courtesy of Photoshare

CONCLUSIONS

Case management was viewed as an integral part of programming in Tanzania, especially at the field level, where staff reported high estimates of the proportion of their time spent on case management. The intentional and separate funding of JSI to conduct pre-service case management training was reflected in the distribution of project expenditure on training. Relatively low spending was observed on case management supervision, even though the supervisors interviewed reported working with high numbers of supervisees. The findings on supervisor ratios are based on a small number of interviews, suggesting the need for review of the caseload borne by CMCs, the impact of LCWs in offsetting this caseload, and the overall quality of supervision services in Kizazi Kipya's programming. Kizazi Kipya CWs and LCWs receive monthly stipends, which account for most of the program's spending on direct CW support. CWs reported out-of-pocket expenses that constituted nearly half of the stipends. An assessment of the impact of out-of-pocket expenses on CW service delivery should be considered.

Kizazi Kipya is a large program reaching beneficiaries nationwide. The cost per beneficiary for case management is shaped by economies of scale, making the program appear less expensive per beneficiary relative to smaller programs. This study was unable to assess how spending decisions on pre-service training and supervision impacted the quality of case management services. New research should consider how the quality of case management relates to cost, to better understand the benefits and drawbacks of Kizazi Kipya's training-driven case management.

The complete study report—The Cost of Case Management in Orphans and Vulnerable Children Programs: Results from a Mixed-Methods, Six-Country Study—is available at https://www.measureevaluation.org/resources/publications/tr-19-327.

REFERENCES

Catholic Relief Services. (2017). Case management in OVC programming. Retrieved from https://www.crs.org/our-work-overseas/research-publications/case-management-children-orphaned-or-made-vulnerable-hiv

Santa-Ana-Tellez, Y., DeMaria, L.M., & Galárraga, O. (2011). Costs of interventions for AIDS orphans and vulnerable children. *Tropical Medicine and International Health*, 16(11), 1417–1426. Retrieved from https://europepmc.org/abstract/med/21859439

United States President's Emergency Plan for AIDS Relief (PEPFAR). (2012). Guidance for orphans and vulnerable children programming. Washington, DC, USA: PEPFAR. Retrieved from https://www.pepfar.gov/documents/organization/195702.pdf

United States President's Emergency Plan for AIDS Relief (PEPFAR). (2015). *Technical considerations provided by PEPFAR technical working groups for 2015 COPS and ROPS: Orphans and vulnerable children*. Washington, DC, USA: PEPFAR.

This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation cooperative agreement AID-OAA-L-14-00004. MEASURE Evaluation is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of USAID or the United States government. FS-19-341

USAID FROM THE AMERICAN PEOPLE

PEPFAR

MEASURE Evaluation