GHAIN SUPPORT TO ORPHANS & VULNERABLE CHILDREN IN NIGERIA

END OF PROJECT MONOGRAPH

GHAIN
Global HIV/AIDS Initiative Nigeria

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INTRODUCTION

The *2010 Report on the Global AIDS Epidemic* by UNAIDS states that 7,579,151 million children in Nigeria lost one or both parents to AIDS (UNAIDS, 2010).

In 2004 a joint report revealed that millions of children around the globe were orphaned or made vulnerable by HIV/AIDS with 12.3 million orphans in Sub-Saharan Africa alone (Children of the Brink, 2004). The report also indicated that 5.2 million in the region became orphans in 2003, and of these children 800,000 were in Nigeria.

Given the enormous needs of orphans and vulnerable children (OVC) in Nigeria, the Global HIV/AIDS Initiative Nigeria (GHAIN), a comprehensive HIV project funded by the United States Agency for International Development (USAID), began supporting OVC services in 2005. The range and coverage of services evolved throughout the course of the project. In Phase One, from 2005 to 2006, GHAIN supported comprehensive (i.e. facility- and community-based) services to orphans and vulnerable children affected by HIV/AIDS. During Phase Two, from 2007-2008, GHAIN focused on support for facility-based OVC services, primarily consisting of paediatric care and support services for HIV infected children. In this period, the responsibility for providing community-based services in 14 states was transitioned to the Centre for Development and Population Activities (CEDPA). Lastly, during Phase Three, from 2009 to 2011, GHAIN resumed support for implementation of both facility- and community-based OVC services.

When launching Phase Three, GHAIN piloted a comprehensive, local government area (LGA) wide approach to OVC services, beginning in Yakurr LGA, Cross River state and Nassarawa LGA, Kano state. All OVC in these LGAs were enrolled, assessed using the child status index (CSI) and provided with seven essential services based on their needs in an equitable, efficient and cost effective manner. This model was then scaled-up to 12 additional LGAs.

GHAIN's OVC STRATEGY

Phase 1

Besides strengthening the capacity of families to protect and care for orphans and vulnerable children, core program strategies included mobilising and strengthening community-based responses to care for these children and ensuring that they have access to essential services. While the program aimed to support the Federal Government of Nigeria to protect vulnerable children, it also made sure those beneficiaries took a substantive role in program activities.

In this effort, five main strategies were employed:

1. Strengthening the capacity of families to protect and care for orphans and vulnerable children.
2. Mobilising and strengthening community-based responses.
3. Ensuring access to essential services for orphans and vulnerable children.
4. Supporting the Government of Nigeria's (GoN) role in protecting vulnerable children.
5. Ensuring a substantive role for children and youth in program activities.

Instead of focusing solely on children, the program considered the entire family or household as the programming unit. Though services offered by implementing agencies varied, they generally covered health and nutrition; shelter; education, vocational skills training, and life skills; household economic strengthening; psychosocial support; and legal support and child protection. Because Nigeria officially offers free, universal basic education, the program paid for selected levies and exam fees, rather than school fees.

HAST community volunteer chats with a girl during OVC follow up survey at Ekori, Yakurr LGA, Cross River State

To reach orphans and vulnerable children, GHAIN worked intensively with support groups of people living with HIV (PLHIV) and also asked project communities to define and identify households and children they considered vulnerable. The program worked with children living with or affected by HIV as active and respected participants to reduce stigma and discrimination against them. It also forged linkages and collaborations with other GHAIN program components and agencies, a critical step towards ensuring sustainability.

Phase 2

In response to donor requirements, GHAIN was obliged to scale down its budgetary and project activities and close down the OVC component in 2006, two years earlier than the planned end date. As a result, from 2007-2008 GHAIN implemented a facility-based approach to service delivery while Centre for Development and Population Activities (CEDPA), a partner implementing community home-based care (CHBC), took over responsibility for community-based components of OVC care.

GHAIN engaged all comprehensive antiretroviral (ART) sites and a select number of primary health care (PHC) centers to provide comprehensive basic care and support services for children living with HIV (CLHIV) in line with the National Palliative Care Guidance and the United States Government Palliative Care (PC) Policy. Services included: HIV testing and counseling (HTC), basic nursing care, assessment of signs and symptoms (including pain), prevention of malaria and opportunistic infections (OIs), PC medications, nutritional assessment; psychological care including adherence counseling for children and their care givers, pain control; non-ART laboratory services; referral support for ART and other medications. GHAIN established strong linkages with CEDPA to provide CHBC and other support services for CLHIV.

Phase 3

In 2009, additional funding was made available for GHAIN's OVC program. In this phase, the project adopted a LGA-wide OVC program with the following objectives:

1. Create awareness on the need for care of OVC through advocacy/sensitisation and ascertain the magnitude and needs of OVC
2. Build the capacity of service providers, caregivers and program managers to provide quality care and support for OVC while reducing stigma and discrimination
3. Promote access to basic essential services (health, education, nutrition, legal protection, economic empowerment, shelter and psychosocial) necessary for the optimum growth and development of OVC
4. Build the capacity of OVC to participate actively in program planning, implementation, monitoring and documentation
5. Build partnerships and strengthen coordination to ensure that OVC benefit from a comprehensive package of services
6. Involve policy makers and the media for effective dissemination of key messages to address the growing scale of orphaning and engender community support for OVC programs

GHAIN's LGA wide OVC program covered the following LGAs/States: Nkanu West and Udi (Anambra state), Bauchi and Shira (Bauchi state), Oju and Katsina Ala (Benue), Calabar Municipal and Yakurr (Cross River), Orhionmwon (Edo), AMAC (Federal Capital Territory), Nassarawa and Wudil (Kano), Ajeromi (Lagos), Wamakko (Sokoto).

The eligibility criteria for an orphan and vulnerable child in a GHAIN-supported program was a child 18 years old or younger who is:

1. HIV positive
2. Has lost one or both parents to HIV
3. Living with a chronically ill parent from whatever cause
4. Living with frail grandparents
5. Living in a child headed household
6. Living on the street or
7. A child labourer

PROGRAM ACHIEVEMENTS

Phase 1

Between April 2005 and June 2006, the project worked with 31 local implementing agencies to strengthen the capacity of over 5,411 families in 277 communities to care for, support and protect over 14,000 OVC. These children were provided with the seven essential services: psychosocial support, food, education, health, legal support, vocational skills training and household economic strengthening.

At the policy level, the program provided technical assistance to the Federal Ministry of Women Affairs and Social Development (FMWA&SD) to develop the National Guidelines and Standards of Practice on Orphans and Vulnerable Children. GHAIN was also represented on the National OVC Task Team and contributed to the development of the National OVC Plan of Action 2006–2010.

During Phase One capacity building efforts targeted orphans and vulnerable children, their caregivers, implementing agencies, and community and political leaders. Key accomplishments in capacity-building include:

- Five representatives from each IA received training on financial and program management and M&E
- Two individuals from each IA were trained to be trainers. Training activities covered reduction of stigma and discrimination, healthcare, education, psychosocial support, household economic strengthening, and community mobilisation
- Seventy-five individuals from a variety of organizations were trained in OVC care and support
- A manual on legal education and will writing was developed and field-tested. Representatives of the 31 IAs and community leaders were then trained with this manual

Based on the strengthened capacity of IAs to provide quality services, GHAIN-supported sites increased access to critical services for orphans and vulnerable children:

- Provision of direct education support at pre-primary, primary, and secondary levels in the form of school uniforms, bags, sandals, textbooks, and notebooks
- Assistance with re-enrolment of out-of-school children, payment of exam fees and other levies, early childhood development activities, and advocacy to school authorities to waive school levies

- Provision of health education within community settings, thus allowing maximum attendance by the children and their caregivers
- Provision of essential health services, such as routine medical checkups, growth monitoring, deworming, provision of multivitamins and insecticide-treated nets (especially for families with children under 5), and point-of-use water treatment
- Referrals and links to ART services were provided to HIV-positive children and their HIV-positive parents and caregivers

Phase 2

The focus during the second phase was on children below 15 years identified at health facilities.

For the period Jan 2008 to Jan 2009;

- 2,399 HIV+ children received RUTF received ready to use therapeutic food (RUTF) as nutritional support; and additional 576 children with unknown HIV status received RUTF
- 439 children with unknown HIV status received care and support for management of opportunistic infections
- Health care workers were trained on care and support for children infected and affected by HIV

Phase 3

In Phase Three, as an entry point for the community OVC program, rapid assessments of OVC service providers were conducted in all 14 LGAs. Advocacy/sensitization visits and community mobilization activities with policymakers and other stakeholders' were carried out in each LGA prior to enrolment of OVC into the program.

Since the introduction of the community-based OVC program in 2009, GHAIN supported the GoN at all levels, building the capacity of service providers, forming partnerships, and creating linkages to ensure OVC access to comprehensive services. Based on these efforts a total of 82,677 children were enrolled and provided with minimum of three basic services through out the lifespan of the OVC project.

At the national level, GHAIN contributed to the development of multiple OVC-related tools, including the OVC psychosocial manual for implementing agencies, the OVC electronic database (KidMAP) which has now been accepted as a national database called the National OVC Management Information System (NOMIS), mapping tools for OVC services organized by UNICEF. GHAIN also conducted OVC training for state governments on

behalf of the FMWA&SD and actively participated in the review of the OVC National Plan of Action.

At the community-level, GHAIN built the capacity of LGA coordinators, health care workers, CBOs and community volunteers to ensure that OVC were provided with quality care. Key achievements include:

- 695 health care workers, CBO staff, and community volunteers received integrated training on OVC services
- 17 caregivers were trained on MIMAGROWS (fortified cereal) production
- 258 Child Protection Committee members were trained to prevent, report and rehabilitate OVC who are prone to abuse, neglect and exploitation
- 82 OVC and caregivers received vocational skills training
- 48 individuals were trained on the OVC electronic database (KidMAP)
- 137 individuals were trained on OVC follow-up surveys

Through GHAIN's capacity-building efforts, CBOs provided direct support to OVC in the areas of health, nutrition, basic education and psychosocial support. All other services were provided through partnerships, linkages and referrals. Select achievements include:

- 14,386 OVC received educational materials (exercise books, pencils, eraser and rulers)
- 10,794 OVC received preventive measures (immunization, Vit A and Growth monitoring
- 5,027 OVC benefited from mass de-worming
- 4,137 OVC received HIV testing and counselling
- 3,929 OVC benefited from community home based care services
- 6,012 OVC benefited from nutritional supplements (MIMAGROWS)
- 7,227 OVC were issued birth certificate
- 15,230 children participated in the activities at the recreation centres.

Six month follow up survey of enrolled OVC

Between September to December 2009, GHAIN conducted a six month OVC follow up survey using the child status index (CSI) in two pilot sites in Yakurr and Nassarawa LGAs in CrossRiver and Kano states respectively. The objectives of the survey were to determine the status of every enrolled OVC; assess the health, educational, protection, psychosocial, nutritional and shelter needs of the OVC and how best to meet those needs; and identify gaps and potential recommendations in the existing interventions.

The results found that out of 6,028 enrolled OVC, 4000 (66%) were available for the follow-up assessment; of these 90% of the OVC who were assessed at follow-up had received more than three services based on their needs. Results showed an improvement in all domains: the improvement in a 'good' score for psychosocial support was 45.38% at baseline to 58.90% at follow-up (p<0.001); for food and nutrition, 24.20% to 33.73% (p<0.001); for health, 36.58% to 49.00% (p<0.001); for education and work, 34.63% to 43.88%; for protection, 31.20% to 45.75% (p<0.001) and for shelter and care, 34.80% to 54.98% (p<0.001).

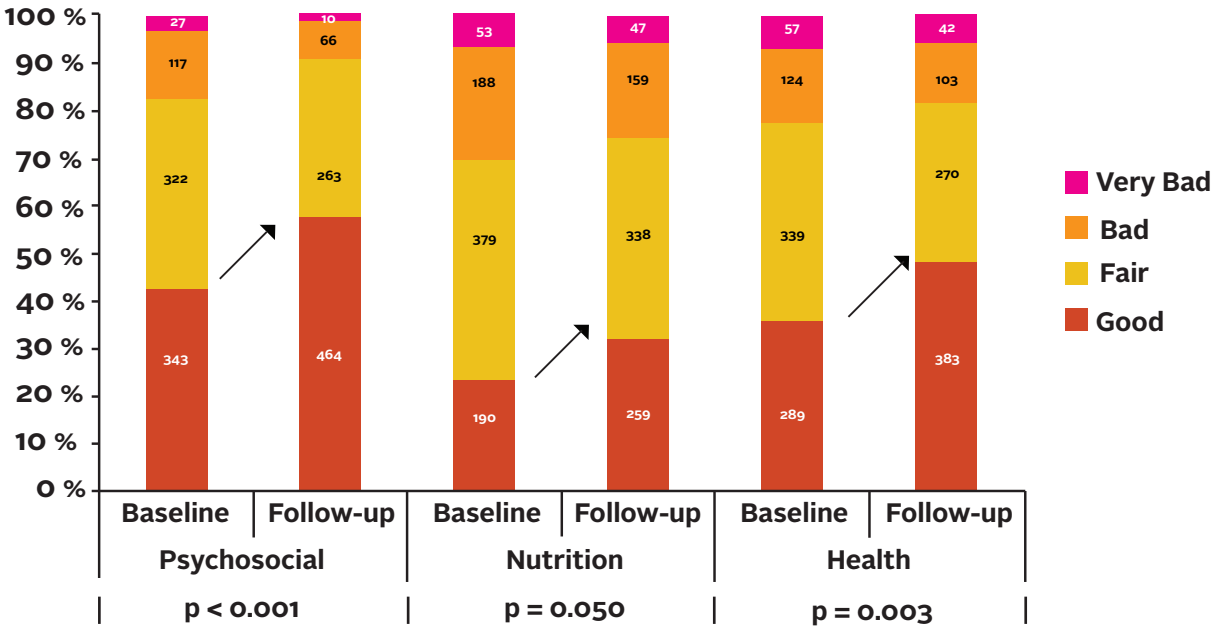

Figure 1: Improvement in CSI scores

DISCUSSION

By linking PLHIV support groups with participatory activities targeting orphans and vulnerable children, the program helped to reduce stigma and discrimination. To further reduce stigma and discrimination against CLHIV, the program encouraged the active participation of children orphaned or made vulnerable by causes other than HIV/AIDS in its activities. GHAIN responded to some immediate concerns of PLHIV, including that their children might forfeit their bequests. In response to these fears, training on legal education and will writing was conducted and a legal support structures set up in the project states.

Despite the successes recorded during the relatively short period of program implementation, GHAIN experienced a number of challenges. Limited experience and implementing capacity made some organisations focus exclusively on the urgent needs of vulnerable children and did not consider psychosocial support and life skills. Capacity strengthening across these other domains was a key component of the program. For most (if not all) of these local organisations, the training GHAIN provided in these domains was the first time they had received any formal training on psychosocial, life skill, and legal support. Developing a balance between short term requirements and long-term priorities is important. Vulnerable children and their households often require essential services to be provided on an emergency basis. However, preparation for long term development is also essential. For example, while it may be necessary to pay school levies for children, it is also important to address the reason that school levies are charged, despite a national free education program.

Budget constraints and increased demand for services was an issue as nearly all implementing agencies identified more vulnerable children and households than the agreed upon program limits., This stretched limited resources and compromised the program's quality, impact, and sustainability.

Additionally, volunteer fatigue and the desire for incentives and remuneration for paid staff and project volunteers were recurring challenges, along with high expectations from children and caregivers that program resources could not meet. With the rollout of free VCT, PMTCT, and ART services, more children and adults were identified as HIV positive and accessed treatment. The program's care and support services could not keep pace with the

increasing number of children living with or affected by HIV in need of support.
Due to donor requirements on funding levels, GHAIN scaled back its budget by closing down the OVC program in 2006, before the program end date. This posed a major challenge for GHAIN, the implementing agencies, and project communities, and risked undermining the acceptability of future programs in these communities.

During Phase Three, vulnerable children were referred for relevant services at enrolment based on their areas of need. In the case of OVC enrolled at health facilities there were two types of referrals: 1) within the facility from one point of service to another within the same facility (intra facility referral), and 2) from primary health care facility to secondary health care facilities and community services (inter-facility referrals). Similarly OVC enrolled within the communities were referred for relevant services at health facilities or to other service points such as schools and CBOs.

Monitoring of GHAIN-supported OVC services was achieved through an innovative approach using an electronic database to monitor each enrolled OVC. The database was known as KidMAP and in June 2011 was adapted by the GoN as the National OVC Management Information System (NOMIS).

Dr. Kirkland (USAID Mission Director), second left, presents the NOMIS software and source code package to Hajia Zainab Maina (Hon. Minister FMWASD) With them are, left - right, Dr. Nkiru Onuekusi (Director, Child Development), Dr. Otto Chabikuli (GHAIN Chief of Party), and Alhaji Idris Kuta, Permanent Secretary, FMWASD.

In order to ensure good data management in the enrolment of children, steps were taken to properly delineate wards and settlements where the different CBOs operate to avoid multiple enrolments by an individual child. Standardization of unique identification numbers on the enrolment forms was ensured by a systematic centralized process under the guidance of the umbrella CBO in each LGA.

KidMAP an electronic data management system was developed by GHAIN for LGA-wide OVC program. It helps program implementers track OVC records electronically in order to quickly obtain the information they need to make key decisions about quality of service received by clients. KidMAP is designed to increase the efficiency of OVC service delivery by CBOs and to enhance the coordinating capabilities of structures at the state, LGA and national levels for OVC activities.

A data quality assessment (DQA) is carried out monthly by the CBO M&E focal person to validate and clean data. All corrections made to the data are updated in the registers. The DQA report is generated from KidMAP, which is then used to locate the source documents of clients with missing or incomplete data. The ultimate goal of every DQA exercise is to institute appropriate measures to prevent reoccurrence of errors.

During GHAIN's third phase of OVC programming, challenges in the finalization of sub agreements, inadequate capacity at the zonal office level, and limitations in monitoring were encountered. In particular, the process of obtaining approval for sub-agreements with CBOs took longer than was anticipated; this slowed down provision of OVC service delivery. Inadequate capacities at zonal office level made some intended aspects of the roll out difficult and so were not carried out. For example, some zonal office staff responsible for providing technical support to CBOs themselves did not have the necessary skills in early childhood education and production of home made toys. Lastly, a lack of OVC focal persons, staff attrition, and insufficient incentives for community volunteers resulted in inconsistent monitoring of CBOs activities.

CONCLUSION

GHAIN's experience suggests that effective coordination between health facility and community services is critical to the implementing a cost-efficient program and ensuring that every vulnerable child can access comprehensive services based on their needs. Regular follow up of enrolled OVC supports the long-term wellbeing of children.

GHAIN's most recent approach to OVC programming utilized capacity building and development of coordinating bodies and community systems at the LGA level. The project also supported comprehensive and equitable provision of services throughout entire communities. This approach will likely yield long term benefits of cost savings, local ownership and sustainability. Outcome assessment in these communities to measure the effect of GHAIN's interventions would be useful.

Lastly, the survey results from Yakurr and Nassarawa LGAs suggest that inclusion of early childhood care and development (ECCD) in OVC programs is feasible and should be a routine component of services provided to vulnerable children. Program managers should consider innovative ways of including ECCD interventions in all OVC programming targeting young orphans and vulnerable children.

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