

# Swinging to New Heights

## Linking Resources to Build an Integrated Care Network for Orphans and Vulnerable Children and Their Caregivers in Nigeria



Caregivers visiting the umbrella CBO.

Malia Duffy, JSI

A sea of child-sized flip-flops in a rainbow of colors washes up the front steps of the building housing Initiative for People's Good Health (IPGH), a community-based organization (CBO) supported by the Strengthening Integrated Delivery of HIV/AIDS Services (SIDHAS) program in the Yakkur area of Nigeria's Cross River state. The front yard is filled with barefoot children running and playing; a swing set is crowded with children who are swinging as high as they can go, fearless and laughing. Inside, a large and colorful playroom is crowded with children singing along to a video playing on an old television; a little girl naps in the middle of the crowd, oblivious to the mayhem surrounding her. Drawings and other crafts adorn the interior walls, and one prominently displayed poster says, *"I am happy to be me. I may not be perfect. But I am honest, loving and happy. I don't try to be what I am not and I don't try to impress anyone. I am just me."*

Moving deftly among the children are the dedicated staff of this CBO as well as community volunteers, many of whom were orphans and vulnerable children (OVC) themselves who came of age in the organization, and who utilize IPGH as a hub to support the community's children and caregivers who are affected by HIV. Teachers take a five-minute walk from the school after classes have finished to visit with IPGH staff and many of their students, who receive after-school tutoring services and participate in the program's play and support groups. Community volunteers voice their dedication to their communities and to the OVC who are in their charge. Caregivers enthusiastically report that the SIDHAS program provides the training and support that they needed

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This publication was made possible through the support of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the U.S. Agency for International Development under contract number GHH-I-00-07-00059-00, AIDS Support and Technical Assistance Resources (AIDSTAR-One) Project, Sector I, Task Order I.

Disclaimer: The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

**BOX 1. SIDHAS GOAL AND OBJECTIVES**

**Goal:** To improve the well-being of OVC in selected states and local government areas (LGAs) in Nigeria.

**Objectives:**

- Establish a sustainable coordination mechanism among stakeholders at all levels
- Operationalize OVC as a service provision strategy at the LGA level
- Build the capacity of service providers for efficient programming
- Implement needs-based interventions for OVC and service providers in the community
- Develop and implement a monitoring and evaluation (M&E) plan in conformity with the national framework to guide policy and program decisions.

to care for their children’s health, education, and nutrition, and to carry out income-generating activities so that they can better provide for their families.

The SIDHAS program (2010-14) helps to mitigate the risks faced by Nigeria’s OVC through technical assistance to government agencies, health facilities, and CBOs with the aim of providing high-quality, integrated services for vulnerable children and their caregivers. Although the larger SIDHAS program seeks to increase access to care and treatment of HIV/AIDS in states throughout Nigeria, the OVC integration program component has been introduced thus far in Cross River and Kano states with plans to scale up in 2013. SIDHAS’s OVC integration model has demonstrated that leveraging existing capacity and building strong linkages between sectors can improve the efficiency and effectiveness of HIV programs and create a system of holistic services to support affected communities.

**Background**

Nigeria, with a total population of greater than 140 million, has an estimated 17.5 million OVC who account for 24.5 percent of all children in Nigeria (Gana et al. 2011). Of these, 9.7 million are orphans, and 2.4 million were orphaned due to AIDS (UNICEF 2008). Although the overall HIV prevalence in Nigeria is relatively low (3 percent), the absolute number of people living with HIV (PLHIV) has a far-reaching impact due to the large population (USAID 2010). Orphans and vulnerable children in particular suffer from poor health and nutrition, limited educational opportunities, developmental delays, and insufficient social and emotional support. Additionally, OVC are at an increased risk for abuse and kidnapping (Gana et al. 2011). These statistics led the Nigerian government to respond to the crisis by creating a number of policies and action plans that address the multifaceted needs of this heterogeneous group, including the adoption of an integrated approach to maternal newborn and child health service delivery in 2007 (Gana et al. 2011). National Guidelines and Standards in Nigeria, also established in 2007, identified a minimum package of services for OVC which includes food and nutrition, education, psychosocial support, health care, shelter, child protection, clothing, and household economic assistance (Federal Government of Nigeria 2006).

Of this minimum package of services, over 90 percent of local organizations provide food and nutrition as well as psychosocial support; however, only 63 percent provide support for shelter assistance (Boston University [BU] 2009). Working alongside the Nigerian government are a number of nongovernmental organizations, CBOs, and faith-based organizations (FBOs) that seek to boost the government response. The contribution from these groups has been significant, but there are no national data on coverage of services for OVC that includes these partners.

It is thought that there is still significant work to do to reach the needs of all OVC in Nigeria (BU 2009). Despite important progress in creating and enacting policies that advocate for availability of services for OVC, continued gaps exist, particularly for OVC residing in rural areas, children under age 5, and youth over age 17. Additionally, the location of services for OVC does not match the need; areas of high HIV prevalence have insufficient programs for OVC, whereas areas of low prevalence have an overabundance of programs (BU 2009).

The SIDHAS program is working to bridge these gaps, improve service provision for OVC and their caregivers, and enhance the social status and health of OVC. SIDHAS builds upon the notable achievements made by the Global HIV/AIDS Initiative Nigeria (GHAIN 2004-10), which was funded by the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) through USAID and which was the largest HIV/AIDS program ever implemented in a single developing country. One of the GHAIN program’s core strategies was building the capacity of communities to respond to the needs of OVC, including access to health services. Implemented by FHI 360, a global health organization, and funded by PEPFAR through USAID, SIDHAS seeks to sustainably reduce the burden of HIV

and tuberculosis (TB) throughout Nigeria. FHI 360 leads a consortium of nine organizations to fulfill this goal and to increase access to HIV care and treatment services for PLHIV and, in particular, pregnant women in Nigeria. The overall program goal is to assist the government of Nigeria to provide antiretroviral therapy (ART) to 252,000 men, women, and children; provide HIV testing and counseling (HTC) to 1.7 million women to prevent mother-to-child transmission; and for 41,200 pregnant women to complete ART (US Mission to Nigeria 2012). Additionally, the program provides a comprehensive and integrated program that strengthens and builds services for OVC in local government areas (LGAs) in Cross River and Kano states which were selected for implementation due to the initial groundwork in these areas that was carried out during the GHAIN program. In Kano state, the program covers a catchment area of approximately 597,000 whereas, in Cross River state, the program covers a catchment area of approximately 196,000 (National Population Commission 2006).



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Children returning to class.

The SIDHAS integrated community-based program is based on the HIV/AIDS, sexual and reproductive health SRH, and TB (HAST) model, developed

**BOX 2. SIDHAS OVC PROGRAM MODEL**

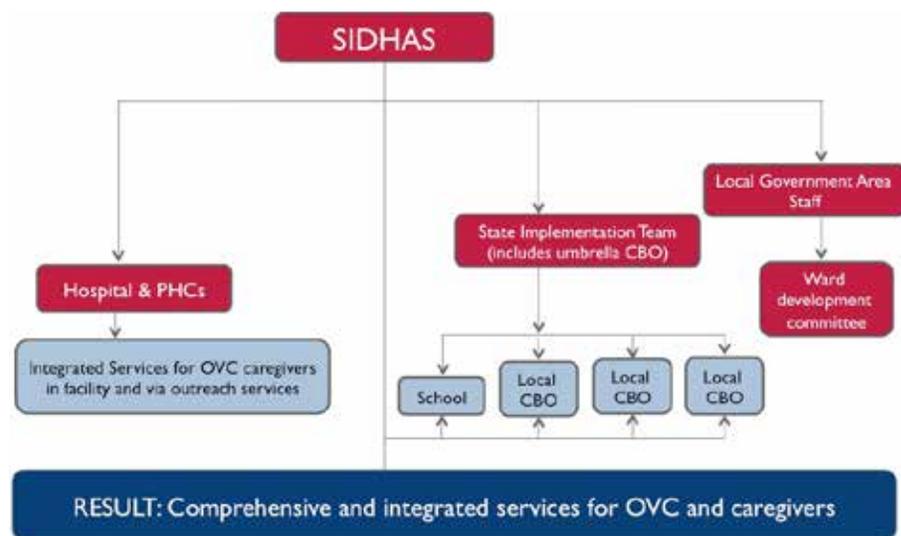
1. Perform rapid community assessment to identify existing resources and gaps in services
2. Identify potential partners in the community to fill in gaps in services not currently provided by CBOs
3. Mobilize community resources, provide advocacy, and create linkages between health, community, and government sectors to provide a comprehensive service program for OVC
4. Train SIT, CBOs, community volunteers, and the LGA to support services for OVC
5. Create a referral directory and mechanism to promote linkages and retention in care
6. Attend monthly multisector cluster meetings to promote harmonization of activities, case management, and sharing of experiences
7. Perform baseline and ongoing assessments of OVC using the Child Status Index
8. Harmonize M&E systems for OVC.

during the GHAIN program. SIDHAS used the HAST model to identify existing community resources that respond to HIV, SRH, and TB among OVC and their caregivers. The LGA, a council that oversees basic health, sanitation, infrastructure, and agriculture, serves to coordinate the integrated approach and creates linkages between community activities and health facilities by building a strong network of referrals and coordinated services (see Box 2) (SIDHAS 2012).

## Implementing SIDHAS’s Integrated OVC Program

Implementation of the SIDHAS program began with a focus on program staff building the capacity of the State Implementation Team (SIT) and the LGA, as well as the capacity of hospital and public health centers (PHC). Over time, SIDHAS has transitioned this model such that the LGA and SIT are now in the position to continually build the capacity of local organizations, creating a sustainable model of service delivery (see Figure 1).

**Figure 1. SIDHAS Technical Assistance Program Approach**



At its inception, the SIDHAS OVC program was designed to ensure sustainability through an innovative structure, the SIT, composed of officials from various government organizations, including the State Agency for the Control of AIDS, the Health Management Board, and the OVC division of the State Ministry of Women Affairs and Social Development, as well as collaborating CBOs. SIDHAS works

alongside the SIT to gradually build ownership of the program and their capacity to implement and supervise the program—thus building ownership of the OVC intervention. SIDHAS also seeks to ensure sustainability by identifying existing capacity within the community and creating linkages between existing resources to ensure a coordinated and comprehensive model of integrated care for OVC that will continue after SIDHAS ends. Figure 1 shows the interlinked elements of the approach. For additional oversight and sustainability, SIDHAS also strengthened LGAs through an intensive training course on HIV, SRH, and TB service provision.

Figure 2. SIDHAS Coordinated Approach to OVC Care



At the outset, the program also retained and recruited community volunteers to identify potential OVC within their areas and link them to a health facility. Each CBO that was identified by SIDHAS was also linked to a nearby health facility, and each child identified as potentially vulnerable was directly referred to the health facility where they were

assessed through the Child Status Index (CSI) tool.<sup>1</sup> Children who met the criteria based upon this assessment were enrolled in the program.

## SIDHAS Local Partners

Each organization received technical assistance to improve their effectiveness in their designated role as follows.

**Health facilities:** The area hospital and PHCs are the focal point for health service delivery within a community and also work closely with CBOs and other community structures. This puts them in an optimal position to guide integration through referrals and linkages to community structures. When an adult client tests positive for HIV, other family members, including partners and children, are identified and tested. All children, regardless of HIV status, are enrolled in an OVC program once a parent has tested HIV-positive. Each hospital has an OVC site coordinator who is responsible for arranging services for OVC within the hospital and creating linkages to services within the community, and also conducts outreach within the community to bring in non-enrolled OVC. In addition to routine health services and HIV care as necessary, health facilities provide related services to OVC, including growth monitoring, nutrition and personal hygiene education, support groups, insecticide nets for malaria prevention, referrals for school enrollment, and referrals to the local CBO.

In addition to the integrated program of referrals and linkages within the community, the district hospital also provides integrated services within its own facility. See Table 1 for the integrated model of health service delivery.

<sup>1</sup> The CSI is a measurement tool that assesses a child's welfare in low resource settings in six domains (food and nutrition, shelter and care, child protection, health, psychosocial issues, and education). The tool also helps to systematically monitor improvement in a child's vulnerability status through periodic measurements (MEASURE Evaluation 2012).

**Table 1. Integrated Health Service Delivery Model**

HAST Intervention at Primary Health Center	Triage/Waiting Area	Acute Care Medical Clinics (Adult)	Under 5 Clinics (Acute Care, Immunization)	TB Clinic	Chronic HIV Care (ART)	Ante Natal Care and Post-Partum clinic	FP Clinic	Adolescent-friendly Clinic or Room
PITC <sup>2</sup> /HTC	x	x	x	x	x	x	x	x
Prevention with positives		x		x	x	x	x	x
Prevention for negatives	x	x		x	x	x	x	x
Acute care for adults: pneumonia, diarrhea, skin conditions, mental health, opportunistic infections, etc.		x			x	x		x
Acute care for children: IMCI <sup>3</sup> for high prevalence settings			x		x	x		
HIV- exposed infant interventions: test, CTX <sup>4</sup> , feeding counsel and support			x		x	x		
Palliative care: symptom management		x	x	x	x	x		x
Screening for STIs		x			x	x	x	x
FP services		x		x	x	x	x	x
Screening for coughs	x	x	x	x	x	x	x	x
Screening for other symptoms, signs		x	x	x	x	x		
Case management		x	x		x	x		x
Promotion of ITN <sup>5</sup> use		x	x		x	x		x
Isoniazid Preventive Therapy						x		

(Ibrahim et al. 2010)

<sup>2</sup> PITC: Provider-initiated Testing and Counseling

<sup>3</sup> IMCI: Integrated Management of Childhood Illness

<sup>4</sup> CTX: Cotrimoxazole

<sup>5</sup> ITN: Insecticide Treated Nets

**The umbrella community-based organization, local CBOs, and community volunteers:**

A single umbrella CBO, which is a component of the SIT, receives direct technical support from SIDHAS. The umbrella CBO provides direct services to OVC within the community and furnishes technical assistance to four smaller local CBOs within their catchment area. This umbrella CBO is responsible for building the technical, financial, and institutional capacity of health facilities, CBOs, and other key actors in SIDHAS. In this role the umbrella CBO provides training and supervision to enable the small CBOs to provide equivalent services to OVC within their communities.

Orphans and vulnerable children are linked to their local CBO through health facility referrals and through community volunteers who provide support to OVC within the villages. The CBO organizes and hosts health facilities to provide bimonthly consultations within the CBO for malaria and diarrhea treatment, de-worming, body mass index tracking, isoniazid preventive therapy for pregnant women, and immunizations. Community-based organizations also promote education for OVC by providing educational materials, paying school fees for the most vulnerable children, offering after-school homework support, and conducting school visits to monitor attendance.

**Skills building:** In order to avoid stigmatization of OVC, all children within the community are invited to receive services at the CBO regardless of their vulnerability status. These services are varied and include “Kid’s Clubs” where the children are taught life-building skills such as decision making, goal setting, effective communication, refusal and negotiation skills, and SRH education. In addition, the program targets caregivers, older children, and children of child-headed households through the household assessments to identify existing strengths

and empower the individual to carry out business in an activity that they are already engaged in. For instance, a girl who cooks for her family may receive training to become a baker and sell baked goods in the market, or a farmer will be trained to grow more crops and sell them in the market. A partnership between IPGH and USAID MARKETS<sup>6</sup> has built the capacity of volunteers to lead the household training for income generation and microenterprise.

Also through CBOs, caregivers receive bed nets to prevent malaria and training on household and personal hygiene, strengthening household finances, monitoring children’s health, and ensuring water safety.

*“They teach me how to go to the market and give my family healthy food. When my children are sick I can bring them here and they help me take care of them. They give us immunizations, bed nets, medicine, my children are okay.”*

*–Caregiver*

**Community volunteers:** Cross River state has 26 community volunteers who are elected by their fellow community members and are a cornerstone of the SIDHAS program. Their responsibilities include identifying OVC in the community, carrying out monthly home visits, providing counseling on nutrition and water safety, delivering psychosocial support, screening for TB and malaria, and furnishing bed nets. The CBOs provide monthly training to ensure that community volunteers maintain high quality services, and the volunteers say that the training is an important incentive for their continued involvement in the program. Each community volunteer is responsible for anywhere between 130

<sup>6</sup> Implemented by Chemonics International, Inc.

and 190 OVC in their community and works well over 40 hours a week to ensure that the children's needs are met. Volunteers are not paid, and rely upon the good will of the community to ensure that they receive the basic essentials to survive. SIDHAS occasionally provides a small amount of money to volunteers to pay for children's transportation to the health facility when they are ill.

*"If you are volunteering, you must understand from what your next door neighbor is suffering. We find happiness at the end of the day because we have helped a child realize their dreams."*

*—Okoi Michaea, Community Volunteer*

**Local government areas (LGAs):** The LGA is a critical link between the community and the district and state authorities in Nigeria. SIDHAS strengthens the Nassarawa LGA in Kano state and the Yakkur LGA in Cross River state to provide technical support and supportive supervision for the integrated program at the community level; once the program has ended, the LGA is expected to take the place of SIDHAS. The LGA provides technical assistance to all organizations that are serving OVC within the area and visits health facilities twice a month to monitor activities and provide supportive supervision. Supervisory visits include ensuring that all work is carried out according to standard operating procedure, checking that programmatic data is captured at all levels, verifying that data is correctly reported, and preparing the budget for health facility activities. Local government area focal persons also meet monthly to carry out a review of all data, identify gaps in services and outcomes, share experiences, brainstorm, and provide targeted

activities in response to identified gaps. The LGA is divided into 10 separate wards, which is the smallest political and geographical unit in Nigeria. The LGA authorities meet quarterly with Ward Development Committees to hear issues within the ward and help to identify ways to overcome issues that are identified in regard to health services, including linkages and referrals.

The LGA is also responsible for the Child Protection Committee, which ensures that information on child abuse is communicated to the community. The committee consists of education officers, representatives from the umbrella CBO, traditional rulers, and representatives from the National Population Committee and the Social Welfare Commission. These stakeholders are brought together to ensure a coordinated and effective response to child abuse and kidnapping. At Child Protection Committee meetings, individual cases are addressed and police are involved in response to kidnappings and rapes. The chairman of the committee works to empower parents to report child abuse when it occurs within the family setting, helps to improve security within schools to decrease the likelihood of kidnapping, and builds the capacity of teachers to recognize and report child abuse. Traditional healers, mothers, and church members have also been mobilized at the community level to recognize and report child abuse.

*"What keeps me going is the passion of the job. Today I keep learning; I have learned of illness which I never knew before. And now in my community they call me 'nurse' and they knock on my door at night looking for solutions."*

*—Isu Dati, Community Volunteer*

**Community pharmacists:** There is a dearth of qualified pharmacists to staff pharmacies at hospitals and primary health centers in this region. To overcome this gap, FHI 360 partnered with Howard University to train a pool of volunteer pharmacists to attend to clients at hospitals and health centers. The volunteer pharmacists are trained to dispense routine medications, and also to carry out HTC of pregnant women and refer them to the hospital if they test positive.

**Traditional Birth Attendants:** Traditional birth attendants (TBAs) also receive training on HIV and routinely communicate with the hospital when a pregnant woman in their care is HIV positive so that she gives birth in a health facility. If an HIV-positive woman gives birth in the community, the TBA is instructed to bring in the pregnant woman immediately postpartum to receive prevention of mother-to-child transmission (PMTCT) services at the health facility.

**Teachers and the Early Childhood Care and Development Program:** SIDHAS established a referral system for teachers who recognize OVC in their classrooms to refer them to CBOs. However, it should be noted that the CBOs accept all children who would like to receive services regardless of OVC status. They believe that this helps to destigmatize OVC within the community and increase the likelihood that an OVC will access services. Community-based organizations sometimes also work with the schools to offset school fees for OVC to improve school attendance by providing school supplies and materials, which contributes to the school as a whole, rather than by paying fees directly. Additionally, SIDHAS instituted Early Childhood Center for Development (ECCD) centers within schools to provide young OVC and their caregivers with psychosocial support, nutrition education, food and vitamin supplementation, protection, and shelter. The ECCD centers also

provide a range of health services, including immunization, de-worming, filters for safe drinking water, bed nets, and basic care kits for OVC who are living with HIV.



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Children attending school where ECD services are offered.

## Linking Services within the Community

Due to its multisectoral approach for OVC, the SIDHAS program requires a strong network of referrals and linkages. When a referral is made for an OVC, triplicate carbon copy forms are made. One copy is maintained at the originating organization; one is given to the client to bring to the receiving organization; and the third is brought by the referring provider to the monthly “cluster meeting,” at which all referrals within the program are reviewed. SIDHAS has leveraged already existing Global Fund work in Yakkur, including the monthly cluster meetings. Cluster meetings take place at the hospital to discuss improving referral networks and HIV care in general. In attendance at the meetings are representatives from private health facilities, FBOs, CBOs, PHCs, community volunteers, LGA authorities, as well as representatives from patient support groups. The monthly cluster meeting is a crucial element to maintaining an organized and efficient integrated system of referrals.

**BOX 3. EXAMPLE OF INTEGRATED SERVICE PROVISION AT THE HEALTH FACILITY**

Scheduled immunization days for children occur every other week. While mothers and caregivers are waiting for their children to be immunized, they receive education on family planning, HIV and STI prevention, nutrition, exclusive breastfeeding, and information on improving personal hygiene. Any women who desire family planning services (funded externally by SIDHAS) or HIV/STI testing may have these services during the same visit. Health facility staff report that this model has led to reduced stigma surrounding HIV, while the interactive nature of the visits has improved interpersonal relationships between staff and clients.

Each time a referral is made, the referring organization checks in with the referee organization to ensure that the client followed through on the visit. When a client does not complete a referral, community volunteers and volunteers from the HIV peer support group at the health facility follow-up to determine the cause of the missed visit and help the client complete the referral. This requires a strong communication system between all organizations within the program and relies heavily upon the volunteers, who carry out the leg work to bring the clients back. Coordinating services between health facilities and organizations in the community has enhanced community partnerships, and has also increased the availability of services for those who are hesitant to use formal health care services because of fear of stigmatization or inability to pay.

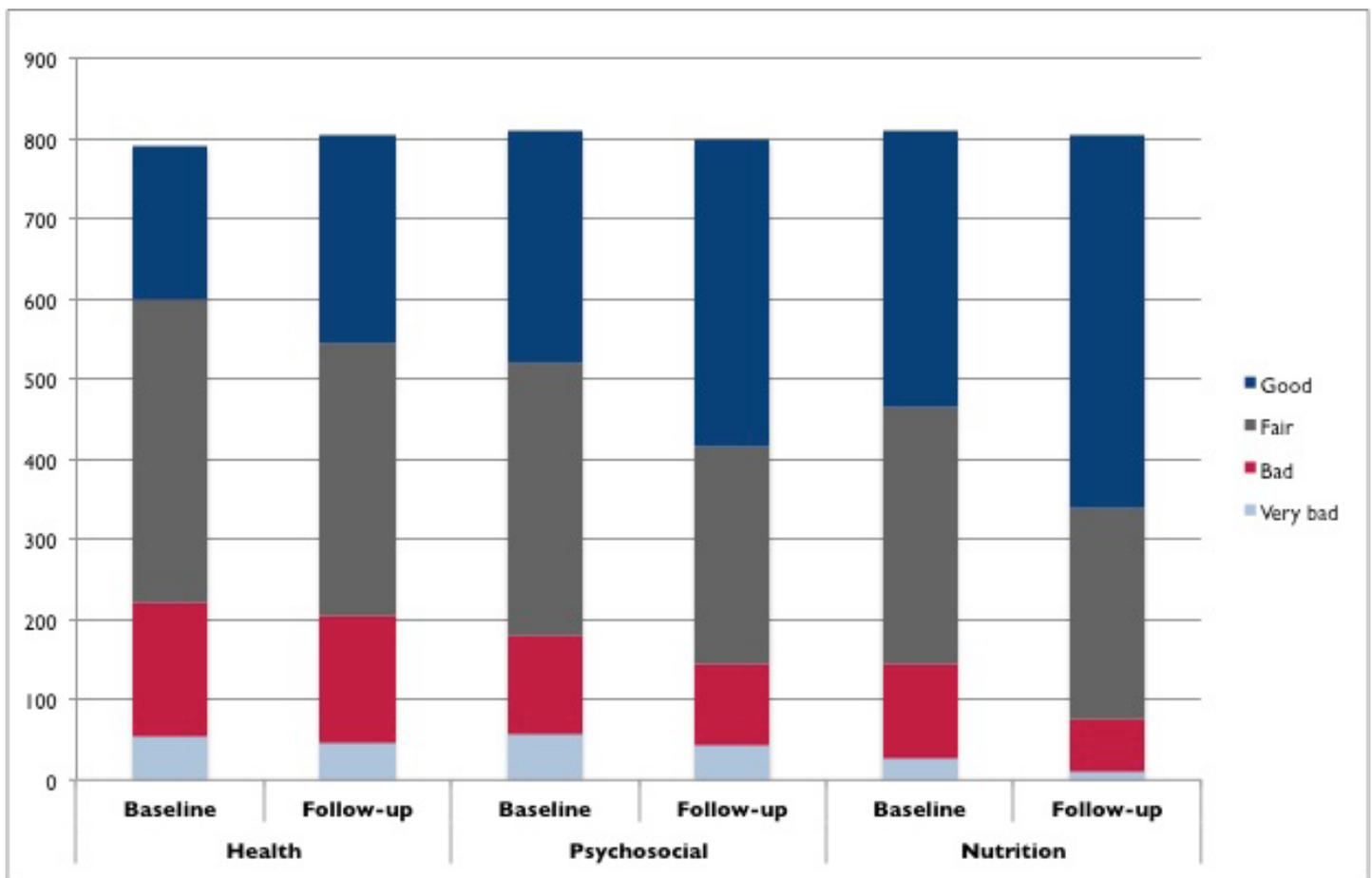
**Monitoring results:** The SIDHAS program utilizes an electronic database (formerly KidMAP and now NOMIS) to harmonize data and coordinate services between organizations, carry out routine and rapid assessments of OVC services, and ensure that CSI scores can be quickly and easily retrieved. Experiences are shared, and data reviewed, at a monthly monitoring and evaluation (M&E) meeting attended by M&E officers from health facilities, CBOs, and the LGA. The LGA M&E officer validates the data received from attendees and enters it into the District Health Information Software (DHIS), where it is reported to the local, state, and national government.

**Number and type of services provided:** Building on the foundation created during the GHAIN program, SIDHAS was quickly able to meet each target established at program outset. A large part of SIDHAS's success can be attributed to its model of building local capacity and strengthening linkages between existing structures. Since the beginning of the program, a total of 7,092 OVC have been enrolled across both programs (Kano and Cross River state) and surpassed the established targets in both states. Of all enrolled OVC, 99.8 percent have received at least one nutrition-related service; 98.4 percent have received at least one health-related service; 73 percent have received at least one psychosocial service; and 90 percent of children surveyed had received at least three different types of program services within a six-month period.

## Results

The median CSI score at baseline in all six domains was three (four is the highest possible score in any one domain). A six-month follow-up CSI measurement demonstrated statistically significant improvements in each domain of the CSI with median scores of four in the psychosocial and shelter domains. Graph 1 compares CSI scores between baseline (January-June, 2010) and follow-up (July-December, 2010).

**Graph I. Change in Psychosocial, Nutrition, and Health CSI Scores**



Measurements at baseline and at six months also demonstrate significant improvements in a number of other program areas. Orphans and vulnerable children service integration resulted in significant increases in the proportion of women receiving antenatal services, having a skilled birth attendant present, and receiving family planning services. Additionally, a significantly greater proportion of children were exclusively breastfed, received treatment for malaria, and received weight monitoring during the same period.

**Table 2. Integration Program Results for OVC and Caregivers**

OVC Integration Program Results, Baseline and Follow-up		
Indicator	Baseline (January-June 2010)	Follow-up (July-December 2010)
Antenatal total attendance	318	991
Deliveries by skilled birth attendant in the community	7	69
Children <6 months exclusively breast fed	138	755
Children <5 years with uncomplicated malaria receiving Artemisinin-based combination therapy	12	654
Children aged 0-59 months weighed	817	3,337
Individuals 15-49 years using modern contraceptives	123	191
Clients receiving family planning services within the community	0	87

## What Worked Well

### **Strengthening existing resources:**

The framework for this integrated model of care is built upon identification and utilization of services that were already present within the community, rather than building new structures and services. Once SIDHAS identified these resources, they were linked to each other to create a holistic program for OVC and their caregivers. By building the capacity of existing resources, SIDHAS has created a program that builds community engagement, strengthens the impact of current programs, and increases likelihood of sustainability of the interventions, since these resources are not dependent upon SIDHAS for survival.

**Building community ownership:** A large part of the program’s success can be attributed to engaging community gatekeepers. At program outset, SIDHAS staff approached members of the Village Health Committees, which includes

religious and government leaders as well as other informal community leaders, to engage them in the program planning and implementation process. This engagement increased the visibility of the program and provided an endorsement from community leaders. The work of the community volunteers, who are elected by the community, further increases community ownership, because community volunteers are the local face of the program. Program participants also believe that building community ownership has increased access to and utilization of services, because community leaders typically are able to identify OVC and can link them to community volunteers.

### **Enabling policies that allow free care of children and pregnant women:**

Cross River state recently enacted a policy that all children under age five and pregnant women are to receive free health care services. This policy highlights the potential vulnerability of these groups and increases their access to health services,

but is not universally applied in all cases at the service delivery level—some facilities provide free services while others do not. SIDHAS believes that in health facilities that enforce this policy, outcomes for children under five and pregnant women are better and are a contributing factor in the SIDHAS program's success. Community volunteers and caregivers also state that although the free services policy is admirable, they are still concerned about OVC over age five, who are no longer eligible for free services.



A group of community volunteers visiting the umbrella CBO.

### **Programmatic and case management through monthly cluster meetings:**

On a monthly basis community volunteers, representatives from the hospital, PHCs, CBOs, the Ward Development Committees, and the LGA, as well as community and church leaders attend a cluster meeting where challenges for OVC that are identified in the field are discussed. The committee works together to identify potential mechanisms to overcome these challenges and, additionally, individual clients who may be particularly vulnerable, or problematic in terms of staying engaged in the program, may also be discussed to ensure that they

receive the services that they need to decrease their vulnerability. The cluster meeting forum has further increased community ownership and involvement, and decreased some of the burden from the community volunteers who are carrying out much of the work in the field. The presence of cluster meetings also helps the SIDHAS program keep abreast of ongoing programmatic challenges and provide technical assistance to address them.

## Challenges

### **Reliance upon SIDHAS for specific types of funding:**

Community volunteers rely upon SIDHAS for funds to provide transport of clients to health facilities when issues arise. Additionally, SIDHAS also supports school fees or provides materials in place of fees for children who are in need of additional economic assistance to attend school. This reliance may be problematic when the SIDHAS program comes to an end unless an alternative means of funding is provided. Engaging the SIT to provide the stipend to volunteers will improve the ownership and sustainability of the program. Any program seeking to replicate this model should engage the SIT to provide this support from the outset of the program.

**Engaging the LGAs effectively:** Currently the partnership between the LGAs and SIDHAS is implied; there is no sub-agreement or any other type of formal partnership. SIDHAS has provided technical support to the LGA so that they can effectively carry out supportive supervision and technical support during the program and well beyond the life of the program. Because there is no policy in place that requires the responsibility for this transition of technical support to occur, it has been problematic for SIDHAS to gradually transition responsibility of the program to local authorities.

Creating a policy that requires LGA involvement and outlines their specific responsibilities will enhance their role and increase the program's sustainability.

**Documenting services:** Participants in some aspects of the program, including the child protection component, have not yet begun to document the services that they are providing. Although it is clear that these services are being offered, and that they are highly visible within the community, without documentation it is difficult to understand either the intricacies of the technical approach or program outcomes.

**Meeting the needs of OVC in hard-to-reach areas:** Although Cross River state has recently improved road infrastructure, in the Yakkur area where the program is implemented, there are still a number of OVC who are hard to reach because road conditions remain poor in some areas. Community volunteers, who rely upon bicycles to access OVC in their charge, say that some OVC who reside in rural areas of the community are very difficult to reach. Additionally, when an OVC needs access to services, including emergency health services, bringing them into care can be very problematic.

## Future Programming and Recommendations

**Involving TBAs from the outset:** To increase the engagement of TBAs, who are leaders within the community and who frequently visit pregnant women in homes, it may be useful to build their capacity by providing training on HTC services. This will enable TBAs to report results to the health facility quickly. Further collaboration with the TBA may also include building their capacity to deliver PMTCT services. The TBAs should be able to deliver intrapartum

services for HIV-positive women, in case the client is unable to travel to the health facility for postpartum PMTCT services for both mother and baby. Finally, the capacity of TBAs should be built to provide client education surrounding mother and infant prophylaxis and to encourage infant polymerase chain reaction testing, particularly for those women and children who are likely to fall out of care.

**Ensuring strong coordination of activities in the field:** Any program that involves multiple sectors within the community requires a strong system of coordination and linkages. Mechanisms to ensure that activities are carried out in all sectors in an organized and efficient manner should be in place at the beginning of the program. There should also be a reliable monitoring system in place to routinely identify gaps in services and address ongoing issues. This will strengthen service integration and linkages and ensure that when issues are identified there is a forum in which they can be presented and addressed.

**Creatively addressing human resources in program design:** Staff members at multiple organizations within the program suggested considering task shifting or task rotation when designing a similar program. This approach can help to overcome human resource shortages, which is a common problem. Staff members also said that they like the continual learning required by task shifting, which keeps them engaged and interested in their work.

**Identifying clear roles and responsibilities for government authorities:** Clarifying the roles and responsibilities of local and state governments is an important step in program design that increases the likelihood of sustainability for any program. Wherever possible, formal partnerships should be established

and targets for increased government ownership should be in place prior to program implementation. Implementing partners and government authorities should have a clear understanding of their responsibilities as the program is implemented as well as a clear understanding of their increased responsibilities as transition occurs toward government ownership of the program. ■

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## ACKNOWLEDGMENTS

The author would like to thank Catherine Gana of the FHI 360 team, who led the design of the OVC integration program in Nigeria, and whose knowledge and experience were instrumental in the development of this case study. Likewise the author would like to thank Kwasi Torpey and Hadiza Khamofu for their full support and input throughout the case study process. In addition, the author would like to thank the FHI 360 staff in Calabar and the Cross River state Ministries of Health and Education. A very special thank you to all of the Yakkur area

staff at the health facilities, school, and IPGH as well as the community volunteers and caregivers who shared their valuable time, knowledge, and experiences. Finally, thanks to the USAID/Nigeria Mission, including Philomena Irene, Carl Hawkins, Ezekiel James, Sola Onifade, Doreen Magaji, and Trevor Rittmiller for the technical insight and financial support of this case study.

### RECOMMENDED CITATION

Duffy, Malia H. 2013. *Swinging to New Heights: Linking Resources to Build an Integrated Care Network for OVC and their Caregivers in Nigeria*. Case Study Series. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

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