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Family Health International

**SITUATION ANALYSIS AND
MOBILIZATION PROCESS
FOR ORPHANS
AND OTHER
VULNERABLE CHILDREN:**

**Ajeromi/Ifelodun and Lagos
Mainland Local Government Areas,
Lagos State, Nigeria**

**SUMMARY REPORT
December 2001**

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AJCPH	Ajgunle Community Partners for Health
AMCPH	Amukoko Community Partners for Health
BASICS	Basic Support for Institutionalizing Child Survival
CEDPA	Center for Development for Population Activities
EA	Enumeration Areas
FHI	Family Health International
FGD	Focus Group Discussions
FMOH	Federal Ministry of Health
FOS	Federal Office of Statistics
HIV	Human Immunodeficiency Virus
IMPACT	Implementing HIV/AIDS Prevention and Control
LGA	Local Government Area
MTCT	Mother To Child Transmission
NACA	National Action Committee on AIDS
NASCP	National AIDS/STD Control Program
NGO	Non-Governmental Organization
OVC	Orphans and other Vulnerable Children
PABA	People Affected By AIDS
PLWHA	People Living With HIV/AIDS
RA	Research Assistant
SFH	Society for Family Health
STD	Sexually Transmitted Diseases
SWAAN	Society for Women and AIDS in Africa Nigeria
WIN	Women in Nigeria

1. INTRODUCTION

1.1 INTRODUCTION TO THE OVC SITUATION ANALYSIS AND MOBILIZATION PROCESS

Overview of the OVC Situation in Nigeria

The HIV/AIDS situation in Nigeria has reached an explosive phase with national average prevalence rate of 5.8% as revealed by the 2001 sentinel sero surveillance study conducted by the National AIDS/STD Control Program, Federal Ministry of Health. It is estimated that 2.6 million Nigerian adults are currently infected with HIV while it is projected that by 2003, 4.9 million Nigerian adults will be living with the AIDS virus. This is bound to have major socio-economic impacts on the Nigerian society; including life expectancy, increased burden of medical care, decline in economic growth, and an increase in the number of orphans and other vulnerable children.

Background literature on the impact of HIV on children and estimates of the OVC situation in Nigeria are extremely limited. Of the available data, Children on the Brink 2000 (based on modeling of U.S. Census Bureau data) reveals that about 590, 000 children have lost one or both parents to HIV/AIDS in Nigeria. Additionally, currently 8.6% of children less than 15 years old are orphans and 27% of maternal and double orphans are due to AIDS in Nigeria. By the year 2010, it is projected that these percentages will increase from 8.6% to 11.5% for the total number of orphans under 15 years of age and more than two fold from 27% to 64% of maternal and double orphans due to AIDS. Yet, these numbers do not reflect the situation of other children who are made vulnerable by other circumstances such as living with ill parents or living in extreme poverty conditions, of who some are often worse off than some orphans. For a country like Nigeria with a total estimated population of 120 million and a young population pyramid with majority of the population less than 15 years, these orphan projections are staggering and have great implications for the entire nation.

Background of the development of the OVC Situation Analysis and Mobilization Process

A recently conducted in-depth assessment for care and support for People living with HIV/AIDS in 4 states (Anambra, Lagos, Taraba and Kano) had revealed gaps in data regarding the current status of OVC services and coping strategies within the communities. This was due to the complex and unique nature of designing a participatory community based programs, with intent to mobilize the communities and build their capacity to enhance implementation and ownership of the programs.

It is widely recognized that to implement a community-based OVC project, formative information should be gathered through a participatory process whereby community members are actively involved and mobilized to identify children mostly in need and priorities for strengthening community structures that are capable of providing necessary

support and training. Community members should also be part of the design of activities needed to support OVC services and mechanisms to monitor and evaluate the effectiveness of these programs in order to increase community ownership and responsibility for the well-being of children. Community involvement is extremely important given the long-term nature of the impact of HIV on children and their families. Even if current levels of HIV infection were to level off today in the country, the number of children in need of care and support will continue to rise for decades to come.

The FHI in-depth assessment had also identified Implementing Agencies (IAs), some of which are already being supported by FHI, to provide care and support services to PLWHA and PABA within their communities. They are also informally working, within their communities to address some of the needs of the children affected by AIDS. These FHI/NGO partners (SWAAN, HHO & SMLAS) have identified orphans and vulnerable children through their projects and have been informally involved in the provision of care and support services to them. However, the degree of support for the children has been very limited in geographic scope and the kind of support provided. The need to strengthen their technical capacity and expand the scope of their work cannot be overemphasized. These Implementing Agencies (IAs) are crucial to the development of OVC services under the redesigned IMPACT project in Nigeria.

As part of efforts to design OVC services, Family Health International worked with key partners, including representatives from identified IAs and the public sector to conduct a qualitative and quantitative assessment of the OVC situation in the IMPACT/Nigeria focal states. This was based on the recognized need to adequately address and build a strong foundation for sustainable and cost-effective OVC projects that can be replicated elsewhere. The information gathered here will also provide baseline data to facilitate the monitoring and evaluation of the interventions as well as contribute to the documentation of OVC situation in Nigeria and lessons learned in conducting OVC work. This assessment is the first stage of a series of steps in the development of what is hoped to be a mobilized national and state level response to the situation of OVC in Nigeria. It is also intended as a first step to develop OVC projects in four states with two additional priority states Ebonyi and Osun States, bringing the total to six.

Research Team and Mobilization Process

An important factor of the OVC situation analysis was to mobilize key stakeholders around the issues affecting orphans and other vulnerable children in Nigeria. Therefore the research team was comprised of representatives from the following organizations and ministries in Nigeria:

- ◆ UNICEF
- ◆ NASOP
- ◆ Federal Ministry of Women Affairs
- ◆ The Policy Project
- ◆ FHI/IMPACT Implementing Agencies
- ◆ Local consultants including a psychologist and pediatrician
- ◆ Microfinance/Microcredit experts
- ◆ Federal Office of Statistics
- ◆ FHI/Nigeria
- ◆ FHI/DC

The research team was involved in the development of the entire situation analysis process including objectives, design, data collection, analysis and report writing. Based on observation and feedback from the various team members the experience of conducting this assessment has increased their motivation, understanding and commitment to strengthen and advocate for the improved well being of orphans and other vulnerable children in their respective professions and personal lives. Many were touched by what they heard and felt during this process. This experience also forced them to look at their own lives and experiences and challenged them to review their thinking on the subject.

It is the opinion of all involved that a situation analysis of this nature not only be conducted to fulfill the outlined objectives but also to mobilize individuals into action and be used to implement programs that will benefit current and future generations. Hence, the work will not stop here but continue through coordinated efforts and action.

The results of this situation analysis and mobilization process will be presented at the first OVC Stakeholders meeting on Monday March 25, 2002 in Abuja, Nigeria. The objectives of the Stakeholders meeting will be to 1) To provide feedback on the findings from the field assessment, 2) To highlight major problems confronting families and communities and coping mechanisms and structures within communities that can assist in addressing such issues and 3) To highlight the next steps in the development of proposal for OVC work in selected States in Nigeria. The recommendations gathered from the Stakeholders meeting will be incorporated into a final report which will be presented at the first West and Central African Regional OVC Conference in April, 2002 in Cote d'Ivoire and will be provided to the currently being established National OVC Task Team of Nigeria.

Objectives

The objectives of the qualitative and quantitative assessment are to:

- Gather information that will help to describe the impact of HIV/AIDS on children and their families.
- Identify current coping mechanisms within families and communities for orphans and vulnerable children.

... structures, systems and mechanisms that are capable of ... complementing OVC project.

- Identify and assess local NGOs with capacity, experience or potential to participate in or implement community based OVC projects.
- Provide baseline information for the design and the monitoring and evaluation of OVC projects in FHI focal states.
- Provide a baseline for further evaluation in the six states and the monitoring of the well-being of families caring for the orphans and vulnerable children over time.
- Obtain data in a standardized format, which will enable comparison with other OVC studies carried out in other countries.

1.2. METHODOLOGY

Study Population

Six states (Lagos, Anambra, Ebonyi, Kano, Osun and Taraba) were identified for this assessment. Of the six states FHI is implementing comprehensive prevention and care programs in four. Osun and Ebonyi are non-comprehensive program states but have care and support programs being supported by FHI/Nigeria. The six states represent the following Nigeria geo-political zones: (Southwest, Lagos, Osun); (Southeast, Anambra, Ebonyi); (Northeast, Taraba); (Northwest, Kano). Two LGAs were covered in each state one of which was the State capital LGA. It is also noteworthy that three of these states are so called hot-spots (states with HIV prevalence above national HIV prevalence of 5.8%). These states are Lagos, Ebonyi and Taraba.

The study methodology for this assessment is comprised of the following:

- *Key informant interviews* with community leaders (including traditional community leaders, religious leaders and community opinion leaders or spokespersons), health workers (Doctors/Nurses) and teachers.
- *Focus Group Discussions* with three distinct groups : a) community members, b) People Living With HIV/AIDS and c) People affected by HIV/AIDS (e.g., relatives, volunteers and home based care givers)
- *Organizational response and capability assessment*: structured closed and open ended questions administered specifically to organizations with activities related to the issue under study. Such organizations include (but not limited to) organizations providing institutionalized care for orphans and vulnerable children and programs focusing on child survival, safe motherhood, micro credit, home based care, faith based support, etc. as available.
- *Government perception and response assessment*: This will be done using a line ministry tool administered to relevant State ministries such as Education, Health,

Women, Youth and Social Development, etc. Information gathered will include existing policies, state programs, commitment etc.

A qualitative survey checklist was developed to facilitate Focus Group Discussions and the key informant interviews. This will supplement data collected using structured questionnaires, and will be particularly useful in the verification of some of the quantitative data.

Key informant interviews: A minimum of 2 traditional leaders, 2 religious leaders, and 2 teachers (Principal/School head), 4 health workers (Doctors/Nurses) per sub-site (LGA). Each state will therefore have a total of at least 20 key informant interviews. Note however, that there might be important community/spokesperson or opinion leaders outside these categories who may be identified as a result of the key informant interviews. Such identified persons should also be interviewed (if time permits).

Community Focus Group Discussions: Six focus group discussions with approximately 8-10 persons per FGD were recommended per sub site (LGA) as follows:
Four with community members (2 male and 2 female for adults above 24 years)
Two with young persons aged 18-24 (one male and one female)

One FGD was conducted with People Living With HIV/AIDS and another with people affected by AIDS.

It therefore means that a total of 14 FGDs were conducted.

Organizational response and capability assessment: Organizations to be interviewed include: Institutional service provider organization (private and public) NGO, CBO, Religious group. There might be some outside this category who should also be interviewed. Hence, as many NGOs as possible were covered but not less than the recommended five (5). A mixture of organizations were sought to include those providing and working within areas that directly or indirectly benefit children and may include: child survival, safe motherhood, community development programs, microfinance, and other OVC related services.

Government perception and response assessment: Key government officials within line ministry were interviewed to gather information that will include existing policies, state programs, commitment etc.

Quantitative survey

As stated earlier, a quantitative study was also conducted on heads of households/caregivers of orphans and other vulnerable children. The information gathered from the quantitative assessment will be combined with the qualitative

information provided was compiled into one report at a later date. The following provides information on the methodology of the quantitative assessment and is intended to provide more insight to the reader at this time.

Heads of households were interviewed using a culturally appropriate adapted and pre-tested questionnaire designed to gather information on:

- ◆ Coping mechanism
- ◆ Available resources
- ◆ Resource gaps
- ◆ Safety nets that are available and
- ◆ Their perceptions and beliefs about orphans or vulnerable children situation in the families and the community.

Note that a health profile tool for each individual child accompanied the perception questionnaire and was completed for all children under 18 for each guardian interviewed. Interviews took approximately 35 minutes.

The individual child is the unit of measure of interest for this phase of the study. Therefore, sample size calculations were based on variables of interest for children. The variable of interest in this case is the percent of Nigerian children currently reported as enrolled in school. Using the 1999 Nigerian Demographic Health Survey (NDHS) 57% of children age 6-10 are in school. In order to see this figure increase by 10% over 3 years, the number of children for whom this information is gathered needed to be 165. This yields a sample large enough to identify a statistically significant increase of 10% with a 95% CI of .0694 to .2306. In order to compensate for a 5% refusal rate an additional 9 interviews were needed and so rounding up, a total of 175 guardians were interviewed in each LGA of the six states resulting in a total of 2,100 interviews.

Lagos is one of the so-called "hot-spot" states with higher HIV/AIDS prevalence rates than the national rate. For instance, in 2001 the prevalence rate in Lagos was ** percent against the ** percent national rate. The situation of OVC care and support in Lagos is made worse by urbanization. Urbanization limits care and support opportunities, because at the individual level, the urban environment is characterised more by individualism, while at the family level, it is characterised more by the nuclear family, thus depriving people of the extended family and its traditional support capacities. Furthermore, the urban economy is highly monetised and the absence of money puts urbanites in a more precarious situation.

Lagos is also known to have a relatively high number of street children and young street traders. Although statistics are not readily available, the incidence of child labour is also believed to be high in Lagos.

2.0. BACKGROUND: AJEROMI/IFELODUN AND LAGOS MAINLAND LGAS

Ajeromi/Ifelodun Local Government Area

Ajeromi/Ifelodun was created out of Ojo Local Government in November 1996. The LGA is bordered in the north by Surulere LGA, east and south by Apapa LGA and west by Amuwo-Odofin LGA. It has an estimated population of about 600,000 people. Ajeromi/Ifelodun LGA is a cosmopolitan urban slum characterized by overcrowding, mixed tribal settlements, poor environmental sanitation, lack of social amenities and presence of hot spots (brothels) for female sex work..

The most visible economic activity in the LGA is buying and selling which has turned every available space on the streets into markets for all sorts of commodities ranging from foodstuff to clothing.

The study was conducted in five Enumeration Areas (EAs) in Ajeromi/Ifelodun Local Government Area, namely: Omotola Street, Rafiu/Abiodun Streets, Owodunni/Salami Streets, Audu Bale Street, and Imam Sariyu Street (see details in Table 1).

Lagos Mainland Local Government Area

Lagos Mainland Local Government Area is one of the oldest of the twenty LGAs in Lagos State, created in 1976 out of the old Lagos City Council. The LGA is bounded in the north by Somolu LGA, in the south and east by the Lagos lagoon, and in the west by Apapa and Surulere LGAs. The population of Lagos Mainland Local Government Area is estimated to be approximately 372,190. Two major communities in Lagos Mainland LGA are: Ebute Metta and Yaba. Lagos Mainland LGA is essentially an urban LGA,

Although some parts of the majority of the LGA have rural features. These areas are also populated by people from rural areas. These blighted areas are domiciled by predominantly people from rural areas with a high population of fishing people. The study in the Lagos Mainland LGA was conducted in these two communities.

The Local Government is also noted for commercial activities, having some of the popular markets in Lagos, such as Oyingbo market, Sabo market, and Iddo market. There is also the Oko Baba wood processing plant as well as some small and medium-scale enterprises located at Oyadiran Estate.

The Lagos Mainland LG has about 55 primary schools, 33 secondary schools, one special school for the handicapped, an approved school for children and five tertiary institutions. There are seven primary health care facilities in the local government area.

The study was conducted in five Enumeration Areas (EAs) in Lagos Mainland Local Government Area, namely: Omotola Street, Rafiu/Abiodun Streets, Owodunni/Salami Streets, Audu Bale Street, and Imam Sariyu Street (see details in Table 1).

4.1. LINE MINISTRY

A Government performance response assessment was conducted using a line ministry tool administered to various state ministries such as Education, Health, Women, Youth and Social Development, etc. Information gathered included existing policies, state programs, commitment, etc. The following provides an overview of the responses from those interviewed.

4.1.1 Ministry of Women Affairs

- An Orphan was defined as a child without a father and mother.
- The ministry confirmed the age-long practice of extended family system in providing care for orphans and other vulnerable children, which the interviewee noted has not changed. The care is often in the form of parental guardian, provision of shelter, education, clothing and health care.
- Outbreak of HIV/AIDS has increased the burden of care on extended families as a result of children whose parent(s) have died of AIDS.
- Other categories of children in need in the State were identified as destitute, area boys, children living on the street and child labourers, the majority of whom were thought to come from broken homes.
- The ministry has a policy of rehabilitation for these groups of children
- The ministry has established vocational centers at various locations such as Ikorodu and Agege where skills such as tailoring, hairdressing, tie and dye could be acquired. Another centre is currently being developed at Akodo.

It was reported that the programme has turned out reformed area boys and girls who are now self-employed or practicing skills acquired from the ministry's rehabilitation/training centres. However, it was also stated that the activities of the ministry in this regard are hampered by financial constraints and limited infrastructural facility. Thus, the centres can only cater for a limited number of boys and girls, thereby excluding many others that could have benefited from the programme.

The Ministry collaborates with NGOs such as Lions Club, Dutch Women club, American Women Organization, etc. who assist in providing materials and funding to these vocational centres. The Ministry has plans to establish more vocational centers to cater for the needs of OVC.

The ministry requires assistance in the form of logistic support and funds to establish more centres and acquire necessary materials that are needed in the vocational centres.

4.1.2. MINISTRY OF CHILDREN, YOUTH AND SOCIAL DEVELOPMENT

- Orphan care refers to children who have lost one or both of their parents. The ministry's concern is primarily about under-privileged children which could include orphans or other children in need;
- The extended family system of caring for children of the deceased member of the family is still practised but has been adversely affected by the dwindling economic fortune of the families.
- That HIV/AIDS has greatly affected the society in so many ways in that people who have died as a result of the diseases are leaving behind their children.
- That the ministry's policy is to provide care and support for the under-privileged, and to rehabilitate the destitute, area boys and girls and crime prone young individuals.

The ministry oversees different homes for various categories of children. The homes under the ministry's supervision include:

- Oregon Boys' Remand Home for children aged between 8 and 14 years.
- Idi-Araba Remand Home for girls aged between 8-14 years. The home also houses children under 8 years of age.

Children in these homes are taught various types of functional skills, while the educational needs of the children under 8 years are also addressed.

Apart from the homes that are directly under the supervision of the ministry, it also gives support to homes that are run by individuals and organizations in the State.

4.1.3. MINISTRY OF HEALTH

- According to the ministry, an orphan is somebody without a father and a mother. The age range could be 1- 18 years.
- Orphans are catered for both by families and relatives, and the homes for children who do not have relatives who could take care of them.
- More and more orphanages are seen and more philanthropists are also seen. More people are getting involved in providing for orphans/vulnerable children.
- That more people are interested in taking care of the needy/orphans.

- That it is difficult to identify orphans whose parent died of HIV/AIDS because of the lack of proper documentation. This makes it difficult to assess the incidence of children whose parents have died of AIDS.
- The incidence of beggars on the streets is increasing and becoming a nuisance to the community including the cripples and the street hawkers who are also exposed to a lot of hazards.
- That the government sponsors some care to the motherless babies. The state is conforming to the treaty saying "care for motherless babies". The State government provides basic health care for all children under the age of 5 years. It also provides free education to all pupils in government-owned primary school. Most of these policies are not written.
- Structures are continuously put in place to ensure access to facilities and services such as free education, remand home and motherless babies home etc.
- There are no specific programmes that are run by the ministry to care for OVC. However Programmes such as Immunisation exercise, free education and free health care policy for children pupils between the ages of 1-12 years.
- The various programmes by the ministry have been largely successful. Illustrations given by the respondent to buttress this point include: the immunisation exercises, including polio eradication and routine immunisation could be better.
- The ministry lacks adequate fund for its programmes. In this regard, the respondent commented that the government alone cannot cope with the limited funding.
- The ministry collaborates with NGO such as the Red Cross and Rotary Club, and various international agencies such as the World Health Organization (WHO), UNICEF, and USAID for various programmes including AIDS control programme and the National Programme on Immunization (NPI).

The ministry maintains that it requires financial assistance to expand services such as the children's homes and also to improve facilities and materials for skills acquisition by the children.

The ministry also requires assistance in the area of staff training and logistics to sustain the programmes already in place and to initiate new ones.

4.2.0. FOCUS GROUP DISCUSSIONS

In Lagos State *Focus Group Discussions* with three distinct groups: a) community members, b) People Living With HIV/AIDS and c) People affected by HIV/AIDS (e.g.,

relatives, volunteers and home based care givers) were conducted using a standardized focus group discussion topic guide. The following are highlights from each focus group discussion. Six Focus Group Discussions were conducted at the LGA level, comprising one for male youth, one for female youth, two for male adults and two for female adults. Altogether, twelve FGDs were held in Lagos State for the study (Table 6). Two additional focus group discussions were conducted at the State level, one with Persons Living with HIV/AIDS (PLWHA) and the other with Persons Affected by AIDS (PABA) as indicated in Table 6.

Table 6: Focus Group Discussions

Categories	Ajeromi/Ifelodun		Lagos Mainland		Total	
	Target sample	Achieved sample	Target sample	Achieved sample	Target sample	Achieved sample
Male Youth (18 – 24 years)	1	1	1	1	2	2
Female Youth (18 – 24 years)	1	1	1	1	2	2
Male Adult (above 24 years)	2	2	2	2	4	4
Female Adult (above 24 years)	2	2	2	2	4	4
PLWHA*					1	1
PABA*					1	1
Total	6	6	6	6	14	14

One FGD per state was recommended because of the few number of PLWHA groups in Nigeria.

4.2.1. Findings PLWHA AND PABA

The PLWHA FGD under the aegis of Nigeria AIDS Alliance had eight persons living with HIV/AIDS participating. The discussion was held in the conference room of NAA and lasted for a period of 45 minutes. Documented below are responses/consensus from the FGD.

PLWHA:

- Except that they live positively they do not have the ability to live long.
- Their concern is how to raise money to take care of themselves and their children.
- Some PLWHA discuss their HIV status with the family members who wept sorrowfully, and for some after disclosing to their close confidants, they were deserted. As one of the FGD discussants noted, *"I told my newly wedded wife and she left me"*.
- The welfare of their children has changed for the worse since some of them have no job, coupled with the high cost of medical bills while a few said nothing has really changed because they are still working.
- The needs of their children include nutrition, education, shelter, clothing and everything that make life comfortable.
- They are not aware of any place where they can get support.
- There is need to identify the care givers, and who the real orphans are and monitor the care given.
- The existing care is inadequate and not sustainable, and it could be improved by providing for the existing care providers.
- In providing for orphan care, the PLWHA considered it unnecessary to separate children whose parents died of AIDS from other orphans because of the stigma the separation could generate. As one of the discussants remarked: *"the community stigmatizes them and looks at them with pity and sometimes indifferent"*.
- They are willing to serve as volunteer care-givers to OVC, and are interested in attending seminars and training workshops.
- That financial, material resources and organizational support includes health care needs, mobilized from community and organizations who care about orphans and PLWHA.
- That OVC are discriminated by other children.
- That most adults snob OVC and stigmatize some of them. Although some discussants noted that there are some God-fearing women who sympathize with the orphans, provide care and support for them.

PABA:

Nine persons affected with AIDS who are either parents, brothers or sisters of people living with HIV/AIDS formed the focus group for discussion.

Below are comments/ consensus from the discussion:

- Government assistance is needed to take care of their children and relations living with HIV/AIDS. The need for support was attributed to the high cost of medication.
- Parents/relations are for now responsible for the education, shelter, feeding and medical needs of the children or persons affected with HIV/AIDS.
- Diarrhoea, malaria, whooping cough and teething problems are the major medical problems and hospital bills are paid by responsible parents or relations.
- There is a high level of stigmatization by people in the community. People tend to avoid PLWHA once they know their HIV status. As one of the discussants remarked: *"my uncle even ran away when my sister had the disease"*
- The only organization that they know of that provides some help to PLWHA is the Nigeria AIDS Alliance. This is understandable because the discussants were part of the NAA group. However, it gives a confirmation about the activity of the organization.
- There are no options available in the community for now since they tend to keep away from someone if they knew his HIV status.
- That government should continue to let the community know that one cannot contract AIDS by touching the affected person
- The Churches, Mosques and the community can help by providing food and clothing materials to the victims.
- That the teachers are ill equipped to impart knowledge to the students.
- That community attitude is discriminatory and stigmatises PLWHA and PABA.
- There is need for training for PABA on how to care for PLWHA and PABA especially in the different phases of the disease and knowing what to do to help the PLWHA.
- That they offer assistance in form of money, sponsoring education.
- Other children in the community play with OVC and interact with them.
- Adults care for OVC and are kind to them, they don't discriminate against them.

4.3.9. KEY INFORMANT INTERVIEWS

In Lagos State Key Informant Interviews were conducted using standardized instruments. Interviews were carried out with community elders (including traditional community leaders, religious leaders and community opinion leaders or spokespersons), health workers (Doctors/Nurses) and teachers (Table 5). The following are highlights from the interviews.

Table 5: Key Informant Interviews

Categories	Ajeroimi/Ifelodun		Lagos Mainland		Total	
	Target sample	Achieved sample	Target sample	Achieved sample	Target sample	Achieved sample
Traditional Leaders	2	2	2	2	4	4
Religious Leaders	2	2	2	2	4	4
Teachers (school head)	1	1	1	1	2	2
Teachers (school principal)	1	1	1	1	2	2
Health workers (doctors)	2	2	2	2	4	4
Health workers (nurses)	2	2	2	2	4	4
Total	10	10	10	10	20	20

An orphan was defined as a child who has lost either or both parents, while a needy or vulnerable child could either be an orphan or a child whose parents may be living but are experiencing extreme poverty and could not get their basic needs such as education, shelter and food.

The extended family remains the most popular means for caring for orphans in communities, although poverty and economic hardship has adversely affected the capacity of most families to offer such assistance. Hence children in some homes have to work on the streets as hawkers in order to augment family income and to make ends meet.

Some religious organizations offer support to the needy children who are their members.

The number of OVC in the community is increasing because of death as a result of poverty and diseases.

The three major areas of need mentioned by respondents include:

- educational needs.
- shelter needs and
- feeding needs.

It was also observed that awareness about HIV/ AIDS among community members is increasing. However there is still a high level of denial and stigmatization about HIV/AIDS in the community as indicated in the typical response from communities that: *"We have not heard that anybody died of AIDS", "Nobody has died of AIDS in this community"*.

Furthermore, it was observed that some traditional inheritance practices (such as deprivation of mothers of young children) and widowhood practices (such as extended mourning period ranging between 30 to 131 days among tribes) could adversely affect women's right to properties and economic survival and consequently the children of the deceased

4.4.0. ORGANISATIONAL ASSESSMENTS

An *Organizational response and capability assessment* was conducted using structured closed and open-ended questions administered specifically to organizations with activities related to the issue under study. Such organizations included (but not limited to) organizations providing institutionalized care for orphans and vulnerable children and programs focusing on child survival, safe motherhood, micro credit, home based care, faith based support, etc. as available. The following are highlights of data collected.

4 NGOs were assessed in the two LGAs

- **Ajeromi/ Ifelodun LGA**
 - Ajegunle Community Partners for Health (AJCPH)
 - Amukoko Community Partners for Health (AMCPH)
 - "I am pregnant"
- **Lagos Mainland LGA**
 - Women in Nigeria

4.4.1. AJEGUNLE COMMUNITY PARTNERS FOR HEALTH (AJCPH)

The AJCPH is an urban focused membership NGO established in 1995 and located on 202/216 Ojo Road, Ajegunle. The organization is currently registered with the LGA, state government, Corporate Affairs Commission and donor agencies. The Organization came into existence as a result of sensitization from an international organization - Basic Support for Institutionalizing Child Survival (BASICS) funded by USAID.

The members of the AJCPH meet bi-monthly and had its last election on September 8, 2001. The main objective of AJCPH is the promotion of the well being of Ajegunle community members especially children and women. The list of the members of the board and their positions as constituted by the last election dated 8 Sept 2001 is as contained in Annex A.

The board members meet bi-monthly while the last meeting was held on 21 Nov 2001.

The NGOs has 7 paid staff on its list with other 70 volunteer community based workers including a medical doctor and nurses.

Most of the members have undergone training in start-up workshop, supervisory skill, social mobilization and data management. Office equipment sighted include computer sets, typewriter and file cabinet.

Sources of funding for the organization include DYAD Subscription (8 DYADs) and donor agencies who pay full time staff salaries.

The Organization provides the following services

- Childhood diseases prevention through collaboration with LGA health department for routine, immunization and national immunization day
- Promotion of modern day family planning methods
- HIV/ STI prevention programmes.
- Safe motherhood promotion
- Women empowerment and good governance.
- Male involvement in family planning.

The organization believes that the increase in HIV cases generally has brought a new dimension into their focus. This is in the area of care and support for PLWHA. However the organization needs training for its staff in the area.

The AJCPH monitors its programmes through surveys, peer health education and community based distribution. The organization has linkages with BASICS, CEDPA, Office of Transition Initiative (OTI) Communication for change.

Programmes are sustained by individual support and membership subscription, Community participation, Micro credit from BASICS and revolving fund from CEDPA.

The lessons learned include increased community participation and awareness in family planning, child survival programmes and environmental sanitation.

AJCPH requires to a large extent a non-destabilizing community support to improve the local capacity of the organization in community development activities. Such support could be in form of voluntary donation, community mobilization for child survival programme, space donation for community outreach activities such as immunization and

logistic support and training of staff members in care and support for children in need in the LGA. Others include funding for day care centre and training of more TBAs.

4.4.2. AMUKOKO COMMUNITY PARTNER FOR HEALTH (AMCPH)

Amukoko Community Partners for Health (AMCPH) like AJCPH is a membership NGO established in 1995 as a result of sensitization by BASICS. The organization has its headquarters at No 13, Sanni Street, Amukoko in Ajeromi/ Ifelodun LGA.

AMCPH, a private sector initiative was formed primarily to reduce childhood mortality and improve maternal health in the community. It is registered with the LGA, the State government, Corporate Affairs Commission and donor agencies such as CEDPA, BASICS, SFH, and OTI.

The Organization has a Board of Governors that meets forth-nightly. The last meeting was held on 21 Nov 2001. The list of members of the board is as contained in Annex B:

The Secretariat is manned by five permanent members of staff with 30 youths and 76 adult members of the community based workers. The staff members have participated in democracy and good governance workshop.

Office equipment sighted include Sets of Computers, typewriter, Table and File Cabinets

The organization's focus of work include :

- Family Planning
- Prevention of childhood disease
- Promotion of exclusive breastfeeding
- Social awareness mobilization
- HIV/ AIDS/ STI prevention programme.

The main beneficiaries of the organization's services include children and their mothers; adolescent and adult members of the community.

The Organization focus on HIV/ AIDS/ STI prevention is as a result of the current scourge of the diseases and the organization is ready to work with programmes related to children in need or orphans.

AMCPH ensures monthly and quarterly report update on its programmes and activities for proper monitoring and evaluation.

The organization has linkage with CEDPA, BASICS, SFH, SWAAN and AJCPH. The community contributes to the organization's programme in terms of social support while AMCPH activities are sustained by individual membership subscription and fund rising.

Lesson learned from programming so far include self reliance and capacity building.

The areas currently requiring assistance include funding, technical support, office equipment such as audio-visual aids, vocational centre.

4.4.3. "I AM PREGNANT"

"I am Pregnant" is a membership Non-governmental Organization (NGO) founded in 1999 by a coalition of three organizations. The key partners are the Builders (AJCPH, BASICS), Ayota Arts Centre and Vision Child/ Youth of Africa. The Organization is based at No 33 Oyedeki St, off Ojo Road, Ajegunle, Apapa Lagos. The NGO focus is AIDS and pregnancy prevention for adolescents.

The members of the organization meet monthly and conducted their election on 28 July 2001. It is registered with the LGA, the state government and donors agencies which include Ford Foundation and Pathfinder. The organization claimed to have a constitution with Board of Governors who meet bi-monthly. The list is as contained in Annex C. The board last meeting was held on 14 March 2001.

The current staff strength is 8 although the organization has on its list about 20 volunteer youth who are stipends after an activity. The list of staff members is as contained in Annex C. The members have undergone some training program on Peer Health Education, Youth Friendly Services.

The office equipment sighted include Typewriter, Radio, Motion Camera, Still Camera, Drums and Stage.

The sources of funding include the Lagos State government, Ford Foundation, LASACA, LACA and community members.

The organization is involved in the provision of the following services:

- Sexuality Education
- Health care
- Capacity building of Youth Friendly Centres
- Mobile theatre for enlightenment campaigns
- Community theatre workshop for talent hunting

The main beneficiaries of the organization's services are young people between ages 10 and 24 years and parents of youth in the community.

The rising prevalence of HIV/ AIDS has affected the focus of the organization. The original focus of the founding partners were poverty eradication, childhood disease eradication. However the "I am Pregnant" project was specifically formed with a focus on HIV prevention and control among vulnerable adolescents.

The organization is interested in working with children in need especially orphans. However the members of staff have not undergone any training on care and support for OVC. The organization currently supports 5 girls and one boy who were reinstated into

schools in Lagos State. The organization provides school fees and health care for those persons.

The NGO monitors its activity through field survey, neighbourhood festival and activities. It has linkages with Ford Foundation, UNICEF and Pathfinder.

Take -off grant was from the community while sustainability is through project or programmes whom youth pay some stipends for social functions.

Lesson learned include self reliance and need for commitment.

The areas requiring assistance include:

- Technical assistance – Capacity building of staff including management training.
- Office equipment – Computer, Telephone, Fax machine.
- Equipment for youth friendly center e.g. Sewing machines, Drier, mini studio (video, TV, Mixer, graphic engines)
- Logistic support in form of vehicle and public address system.
- Fund to purchase costumes, IEC material, and payment of staff salaries.

4.4.4. WOMEN IN NIGERIA (WIN)

WIN is a Non-Governmental, non-profit making organization that has been in existence for twenty years, having been established in 1982. The organization is national in structure with branches all over the federation. The National Secretariat of the organization is at No. 12, Yovi Street, Wegbo Street, Iwaya, while the Lagos State Secretariat is located at the Nigeria Labour Congress (NLC) office in Yaba.

Members of the organization hold regular meetings, with members of the Lagos State branch meeting monthly (every third Saturday of the month).

The organization operates on a democratic basis with elected officials running the affairs of the organization. Furthermore, the organization has a constitution, as well as a Board of Trustees as represented by the National Executive Committee. The NEC meets quarterly, with the last meeting of the Board having been held in October 2001.

Although the organization is not registered with the government, it was said to be recognized by the government and various agencies. The organization is actually registered with various non-governmental donor agencies such as the United States Agency for International Development (USAID), the United States Information Service (USIS), the Friedrich Ebert Foundation, the Council for the Development of Social Research in Africa (CODESRIA), the MacArthur Foundation; the Ford Foundation, etc.

In terms of staff, the organization has five qualified full-time staff occupying various positions, with four of the five staff having first degree qualifications. However, on-the-job practical training for staff is rather limited. The only type of training that the staff have undergone is the orientation programme which they were given on appointment.

WIN has various office equipment, including fax machine, computer system, photocopier, typewriter and telephone. This gives an indication about the technological capacity of the organization.

Currently, the organization gets funds from various sources, including: members subscription, individual members of the public, donor agencies and occasionally government agencies.

WIN's activities are spread across rural, peri-urban and urban areas of Lagos State. The organization is especially focused on providing awareness and education, especially for women. The organization also offers legal assistance to women, as well as providing political education and micro-credit support to women.

All categories of women benefit from the activities and services of the organization.

It was reported that HIV/AIDS has had some impact on the organization's activities, as a result of the increasing trend of HIV/AIDS cases. The organization has responded to this impact by incorporating awareness activities into its programmes.

Although the organization has also recognized an increase in the need to address the well-being of children in its focal area, its intervention capacity is limited by inadequate funding.

Currently, the organization's activities are not focused on children in need and orphans per se, but it was felt there is a relationship in that by helping women and mothers, the children also benefit. Apart from this, the organization gives assistance to orphanages as resources permit.

However, the organization expressed willingness to work with children in need and/or orphans. Although, the organization's staff have not undergone any training in OVC care and support, they are interested and enthusiastic to be trained in this area.

The organization monitors and evaluates its activities and programmes through visitation and supervision meeting and direct contact with the beneficiaries.

The sustainability of the organization's programmes is ensured through proper monitoring. To this end, the organization usually facilitates the setting up of monitoring Committees for various programmes. These committees are made up of the beneficiaries themselves.

Beneficiaries are usually required to provide sureties (guarantors) before loans are granted. In order to ensure that the loans are properly utilised, loan recipients are usually given appropriate training.

Beneficiaries of loans usually pay back the loans with interest in order to ensure the financial sustainability of the loans scheme.

The organization has learnt some lessons in the course of its activities and programmes, including the realization that some women do not know their rights. This realization led the organization to embark on programmes to create more awareness and enlightenment for women in general.

The organization would require support for institutional capacity building for the provision of office equipment such as functional telephone, computer systems, etc., as well as training for staff in the area of health care for children in need and orphans. The organization also requires financial assistance to be able to extend its micro-credit scheme to other states that are currently not covered.

The organization has linkages with various organizations, including: the United States Agency for International Development (USAID), the United States Information Service (USIS), the Friedrich Ebert Foundation, the Council for the Development of Social Research in Africa (CODESRIA), the MacArthur Foundation; the Ford Foundation, etc.

The organization enjoys a cordial relationship with members of the community, with community members contributing to the organization's programmes and activities, e.g. by attending the organization's activities. The organization maintains an open relationship with the community. Thus, members of the community visit the organization whenever they need help.

5.0 GENERAL RESULTS AND DISCUSSIONS

5.1. DEFINITIONS

One of the goals of the study was to gain understanding of popular definitions/conceptions of key concepts in the study.

5.1.1. Orphan

The study yielded insight into the definition of an "orphan". Most of the respondents identified an orphan as "a young person who has lost both parents and who lives with his/her relatives". This conceptualisation showed that most people in the communities did not think anyone who lost only one parent should be regarded as an "orphan" in the real sense.

The definition of an orphan was further qualified with age. There were few divergences about the age definition, with some respondents contending that anybody (regardless of age) who has lost both parents is an orphan, while some others put the upper age qualification limit at 30 years. This upper limit was attributed to the need for orphans to be educated or trained in order to fend for themselves, on the assumption that someone who is 30 years old should be able to stand on his/her own in life and would cease to qualify for recognition as an "orphan". However, majority of the respondents limited to age qualification to 0 to 18 years on the assumption that an 18 year old person would be matured enough to be independent.

This implies that to many respondents, the term "orphan" connoted a needy status that is compounded by the absence of anybody to help.

5.1.2. Vulnerable children

Vulnerable children were defined as those children who cannot be adequately catered for (basic needs cannot be satisfied) by their parents either because of poverty or for some other reasons. In other words, this term was used to refer to children who are at increased risk due to parent(s) suffering from a terminal illness, high level of poverty, abandonment by one parent, or are living in a household with orphaned children, street children and child beggars.

At the broad level, some respondents expressed the view that virtually all the children in the communities are in need, because many parents are unable to adequately provide for their needs. This, according to the respondents, explains why many children whose parents are alive and living with them go on the street to hawk and to engage in other income-generating activities to augment family income.

5.1.3. Children in greatest need

The respondents also gave some ideas about “children in greatest need” whom they identified to be poor children. Some other respondents gave indicators for inclusion in this category, such as inability of parents to provide basic needs or inability to provide the children with three square meals a day. Relating this to the phenomenon of orphans and vulnerable children, some respondents noted that children whose parents are dead are usually thrown out of houses by landlords. Without anywhere to go for care or shelter, such children are likely to turn to deviance.

Other categories of children mentioned by respondents as belonging to this category include child prostitutes, “area boys”, bus conductors, and hawkers. Some respondents attributed children engagement in prostitution to the need for survival, while some others simply attributed it to frustration. Similar explanations were given for the phenomenon of “area boys” as the respondents believed that many young children will not become area boys if they were adequately catered for or trained, for instance, if their parents had been able to send them to school, or if they could be gainfully employed.

The respondents had a general consensus that children in greatest need should be helped to be gainfully employed, rather than arrested or persecuted.

5.1.4. Household

A household was defined in the popular sense to refer to a group of people who live under the same roof and eat from the same pot.

5.1.5 Head of household

The head of household was defined as the person who shoulders most of the financial responsibility for the upkeep of the household or who has more say in decision-making in the household.

5.1.6. Care-giver

The term ‘care-giver was used with reference to the household to refer to a parent, surviving parent, or guardian who is responsible for children’s welfare.

5.2.0. PERCEPTIONS OF SITUATION

5.2.1. Trend of OVC in community

The majority of the respondents in the two LGAs, including FGD discussants and key informants believed that the incidence of orphans and vulnerable children in their communities was increasing. A concrete indicator of the increasing trend of OVC, as mentioned by the respondents, is the increasing number of area boys and touts at the garages and motor parks. Explanations given by respondents for the increasing incidence

of OVC include the tendency for some parents to give birth to children indiscriminately, without adequate resources for their care. Another important factor is the poor economic situation in the country. As some of the respondents noted, many parents are finding it increasingly difficult to cater for the needs of their children. It was also noted that the inability of some parents to pay their children's school fees makes many children to drop out of school and go into the streets. Some respondents also reported that the inability of some parents to pay their house rents results in their being driven out of accommodations, together with their children, by landlords. More specifically on the incidence of orphanage, some FGD participants blamed poor maternal care in pregnancy, noting that many women die during childbirth.

Some key informants also attributed the increasing trend to economic hardship in the economy which they contend leads to unexpected death, and inability of people to seek appropriate medical help when sick, as well as deaths from road accidents, hypertension, diabetics, etc.

It should be noted that while the respondents believed that the incidence of OVC was increasing, it was still difficult to identify "orphans" in this sense, because many parents tend to conceal the true status of their children. Understandably, this serves to reduce the psychological trauma that the children may be going through as a result of the death of their parents.

5.3.0. ATTITUDES TO AND PERCEPTIONS OF HIV/AIDS AND RELATED ISSUES

5.3.1. Knowledge of HIV/AIDS

The respondents generally demonstrated a reasonably high level of awareness about HIV/AIDS, as most of them have heard about the illness. However, there was an equally high level of denial about its presence or reality in the communities. Most people denied knowledge of anybody close to them who is infected or who died of HIV/AIDS. Actually, a smaller proportion of respondents claimed knowledge or awareness of someone who suffered or suffers from the disease, or who has died of it, but the sick or dead were usually distant unidentifiable people and not relations, neighbours or members of respondents' communities. It seemed to be something that happens to "other people" or "far away", but not to them or anyone near them. Although this could be genuine indication of the rarity of HIV/AIDS in communities, it seems more likely to be a general denial in response to the stigma that is usually attached to the disease.

5.3.2. Community Attitude to HIV/AIDS orphans

Most FG discussants and key informant interviewees said community members do not discriminate against HIV/AIDS orphans, but rather help all categories of orphans. However, some discussants, especially male youth FG discussants in Lagos Mainland

expressed the view that HIV/AIDS orphans are actually discriminated against and stigmatised.

5.3.3. Inheritance practices

The inheritance practices reported varied because discussants were from different cultural backgrounds. In spite of this variation, majority of the responses pointed to the relative deprivation of women in inheritance practices. In most communities, the inheritance practice presumes that most of the household properties are owned by the man. Thus, the properties are shared upon the man's death. The sharing of property is usually supervised by members of the deceased man's (husband's) family. In many situations, wives are denied access to any part of their husbands' property as they are often accused of being responsible for the death of their deceased husbands. Under this pretext they may be chased out of the house without any share of the property which may then be shared among members of the husbands' families. This is even more likely to be the experience of women who did not have any children for their deceased husbands or in some cases, wives who did not have any male child for their deceased husbands. Young wives are also more likely to suffer this deprivation.

Some respondents also said the property is shared among the children of the deceased, with male children being more likely to inherit property than female children under the traditional practice, although many also noted that modern practice does not discriminate between children on gender basis, i.e. male and female children can inherit their father's property. Under the traditional practice, the members of the extended family usually inherit the property if the deceased person does not have a male child. Even when young male children inherit property, the inheritance may be held "in trust" for them until they are matured. A dangerous implication of this is that the children may eventually be denied of the property that was supposed to have been kept in trust for them by greedy elders.

However, it seems that in contemporary society, the sharing of property to the disadvantage of wives is only likely to happen when the husband dies intestate, i.e. without any formal will. When there is a will, the property will be shared in accordance with the directives of the will, although it is not uncommon for desperate family members to disregard the will to deprive wives and young children of their legitimate inheritance.

Some other respondents even said there is usually no property to share because of the high level of poverty in the country.

The inheritance practices reported have implications for the lives of orphans whose mothers may be chased out without any property and with little regard to how to cater for the orphans. If the orphans are given any property at all, in many situations, the more valuable property would have been taken by greedy adult family members, leaving only the "crumbs" of their father's property for the children. When tangible property are shared to children, it may only be nominal as greedy adults pretend to hold the property in trust for the children until they grow up, but such adults may refuse to hand over such

property to the children when they grow up. Thus, young orphans and their mothers end up being deprived and denied of any inheritance from their fathers. The death of a parent, especially the father, may thus put orphans in very precarious economic conditions.

5.3.4. Traditional widowhood practices

The following is summarized from the various focus group discussions and key informant interviewed. Traditional widowhood practices vary by religion, culture and tribe. Some of the traditional widowhood practices that exist in communities, include:

- The requirement for widows to wear “mourning” clothes (usually clothes of dark colours) for specified periods of mourning.
- The prevention of widows from working for stipulated periods of time in order to mourn their dead husbands. (It should be noted that this practice could have adverse economic consequences for widows, especially in terms of earnings. This could also lead to job loss in some cases for employed widows, thus further impoverishing the widows).
- Some widows are required to shave their hair during the mourning period.
- Some widows being made to drink the water that is used to wash the bodies of their dead husbands. The hygiene/health and in some cases psychological implications of drinking this water should be noted.
- Some widows being forced to marry the brothers or relatives of their dead husbands. The widow would be forced out of the house if she refuses to marry the chosen person.
- The incarceration of widows in Muslim families for about four months to determine whether she was carrying the late husband’s pregnancy.

The respondents felt that these various widowhood practices are generally adverse to the conditions of women directly and their children indirectly.

5.3.5. Helpful practices that are no longer in existence

When asked about helpful practices in the past that were beneficial to orphans and vulnerable children, many respondents in the study area mentioned the provision of school meals for children in the past, which however is no longer provided now. They noted that apart from giving children nutritious meals, the school meal was the only food many needy children would have. With the stoppage of this practice, respondents feared that many needy children are made to go hungry.

Another helpful practice mentioned by respondents in Ajeromi/Ifelodun is the fostering of children within the extended family – a practice in which children in need of care were fostered to relations for care and upbringing. People stated that this practice has however

economic constraints. As some respondents noted, what happens now is that some people bring other people's children into their homes and use them more like slaves.

It was also noted that religious leaders in the past used to assist in the upbringing of needy children by taking them into the churches or mosques. This practice, the respondents noted, has also been stopped.

5.4.0. CARE OF ORPHANS AND VULNERABLE CHILDREN

5.4.1. Role of Families in OVC Care and Support

In the discussion of issues about the care of orphans and vulnerable children, many Key Informants noted, that there is no specific individual or group in the communities that is charged with the care of orphans, with the observation that family members are usually expected to take care of orphans of relatives. In many cases, too, as they noted, the burden falls on grandparents. Apart from immediate family members, the respondents also observed that the extended family gives some help, especially in the area of shelter and feeding, education, and clothing. When only one parent dies, children are taken care of by the surviving parent. However, where both parents are dead, the children are taken care of by relatives or grandparents. The respondents generally reported that the incidence of child abandonment is rare in the community.

Furthermore, many respondents reiterated the poor conditions of families and communities, identifying this as the crux of the problem. Although most of the respondents recognised the role of the family in the care of orphans, many also noted that families are increasingly incapacitated in caring for orphans and vulnerable children because of poverty. According to some of the male youth FGD participants, many families are struggling for survival and most are unwilling to take on additional burden of caring for orphans and vulnerable children, although some of them believed that orphans and vulnerable children.

5.4.2. Role of Communities in OVC Care and Support

Beyond the care provided by relatives and other family members, most respondents noted that communities play little or no role in OVC care and support as a body. This they attributed to poor economic conditions. As many, again, remarked, because most families are struggling for their own survival, very few families have spare resources to give to OVC. As one respondent noted, a child that belongs to everybody gets neglected by everybody (a child that belongs to everybody belongs to nobody”.

5.4.3. Role of Faith-Based Organizations in OVC Care and Support

The faith-based organizations also give spiritual and material support to orphans and vulnerable children of their members within the limits of their resources. They cited support given by these organizations included donations of clothes, foodstuff and in

some of the scholarships for education. Although faith-based organizations sometimes extend their philanthropy to non-members, most of the time the focus is on their members.

5.4.4. Role of Medical Institutions in OVC Care and Support

The private medical facilities give limited care and support to orphans and vulnerable children. Some children in need of medical care may be treated free and discharged if they (the children) and their relatives cannot pay the medical bills. However, as some of the medical personnel noted, it is only emergency/acute cases that are treated without conditions, while non-emergency/stable cases may in reality be denied treatment without pre-payment. As medical personnel interviewed noted, it is usually difficult to identify OVC in the hospital, since adult members who take the children to the hospital for treatment usually do not tell any one about the status of the children under their care. Thus, the people who take children to the hospitals are expected to pay their hospital and medical bills. The hospitals may also refer abandoned babies to the police and then to the orphanages for care.

5.4.5. Role of the Government in OVC Care and Support at Community Level

Virtually all the respondents in all categories noted government neglect of needy children in the communities. The respondents further noted that care and support for orphans and vulnerable children in communities have become worse because the welfare homes that were supposed to cater for the welfare of orphans and vulnerable children no longer perform this duty adequately. The respondents therefore called on the government to provide more assistance for the care of orphans and vulnerable children at various levels, including the provision of free textbooks and school fee waiver for OVC in schools.

5.5.0. MAJOR PROBLEMS FACING ORPHANS

The major health problems in community as identified by health workers include: measles, malnutrition, dehydration, malaria, chest infection (bronchitis), Obstetrics and Gynecology problems, typhoid, etc.

Beyond this, the respondents identified the major problems facing orphans and vulnerable children to include: lack of accommodation, lack of education/ functional skills, and lack of economic/financial resources. At the emotional level, most of the respondents mentioned lack of love/neglect of orphans and vulnerable children, as well as maltreatment.

Knowledge of mother-to-child transmission of HIV/AIDS by medical personnel in the area was observed to be limited. Although some medical personnel claimed awareness about strategies to prevent mother-to-child transmission of HIV/AIDS, they could not practice them because of refusal by pregnant women to submit themselves for HIV screening during ante-natal care.

5.7.0. Potential Needs

When asked about the needs of OVC, many respondents mentioned food, clothing, shelter, education, vocational training, and healthcare. As earlier noted, these needs are satisfied only in so far as family resources can satisfy them.

5.7.0. Potentials for OVC Care and Support

The study showed that there is a great potential for care and support to orphans and vulnerable children. Generally, most of the respondents expressed willingness to serve as volunteers for OVC care and support in the community. This they will do through active participation in OVC care and support meetings.

Many youths also expressed willingness to share their limited financial and material resources with orphans and vulnerable children, by sharing money, clothing, foodstuff, etc. Some youths simply said they were willing to give love and support to orphans and vulnerable children.

5.8.0. Suggestions for Enhanced OVC Care and Support

The respondents made some suggestions for enhancing OVC care and support in the community, including the enlightenment of parents and community members about the need for OVC care and support, as well as the need for the government to assist OVC by providing them scholarships for education.

7.0. RECOMMENDATIONS

Based on the findings of this study, the following recommendations were made by the Lagos research team:

- There is need to assist orphans and vulnerable children with scholarships and school fees waiver to improve their access to education.
- There is also need to provide OVCs who are out of the formal school system with functional skills through proper training.
- There is urgent need to provide economic succor to needy members of communities in order to alleviate their economic hardship. Apart from improving their quality of life, such economic support will also help to control the incidence of deviant behaviours, including: prostitution, violence, and crime. This support can be provided by all categories of philanthropic individuals and organizations, including families, non-governmental organizations, communities, religious organizations, and the government.
- Although most of the respondents reported no discrimination against HIV/AIDS orphans, there is still need for more enlightenment of community members to accommodate HIV/AIDS orphans.
- There is need to enlighten community members about the undesirable consequences of inheritance practices in many cultures, especially on women, and the implications of this for orphans and the entire society.
- There is need to enlighten community members about the negative consequences of traditional widowhood practices in many cultures and how these can impact negatively on the widows.
- Families caring for OVC should be assisted, for instance, through tax rebates for identified children.
- There is need for the government to provide more social welfare support, especially for school children, e.g. the provision of free meals in schools. Although, the Lagos State Government recently re-introduced free meal for school children, there still seems to be some problems in the effective implementation of the programme.
- The welfare homes should be resuscitated and rejuvenated to provide adequate care and support to abandoned orphans.
- There is need for special medical provision for OVC, for instance through medical care rebates. Although the Lagos State Government has a free medical service programme, there is need to further improve the delivery of the service to the people.

- There is need to encourage family and community members to show love and care to OVC by accepting them and providing suitable accommodation for them.
- Although the religious organizations currently play commendable roles in OVC care and support, they should be encouraged to do even more in this regard in order to improve the quality of life of the people.
- Care and support intervention programming for OVC, PLWHAs and PABA should be commenced in the study area as soon as possible. Such OVC projects should not be stigmatized as "AIDS orphan" program.
- The assessed NGOs look promising and should be considered for possible support in the area of OVC care and support.
- FHI programmes and research activities should be streamlined so that specific groups and organizations are not made the focus of continuous research, so that the problems of panel studies and similar studies, including sensitisation of respondents, do not set in to affect the information being collected. It should be noted that the PLWHAs in the FHI Implementing Agencies have been studied many time in recent past, collecting more or less the same information from the same set of people.

8.0. LESSONS LEARNED

APPENDICES

APPENDIX I

LISTS OF CONTACT PERSONS AND ORGANIZATIONS

AJEGUNLE COMMUNITY PARTNERS FOR HEALTH(AJCPH)

Name of board members	Position
1. Alhaji Saka Salaudeen	Chairman
2. Mr.Femi Ajayi	Secretary
3. Dr. (Mrs.) F W Omeziri	Project-Coordinator
4. Mr. Ola Odusanya	Treasurer
5. Mr. S Akinlaun	PRO I
6. Mrs. Lilian Onalimi	Chairperson(WEC)
7. Alhaji M Fijabi	Financial Secretary
8. Chief Okpara	President-Cooperation
9. Mr. Olalekan Azeez	Youth Coordinator
10. Dr.(Mrs.) D.C Anameh	Vice Chairman
11. Prince Afinjuomo	PRO II

AJEGUNLE COMMUNITY PARTNERS FOR HEALTH(AJCPH)

Title of staff members	Full time	Part time	Background
Project Coordinator	-	1	Medical doctor
Project manager	01	-	Nurse
Field Supervisors	05	-	Nurse
Community based workers	-	70	comm. members

"I AM PREGNANT"

Board of Governos members

Hon (Dr.) Segun Oyefule	Chairman Advisory Council
Amb. Segun Olusola	Grand patron
Mrs, Stella Obasenjo	Grand patron
Dr. Canice Omeziri	Patron
Chief Rabiun Oluwa	Patron
Chief (Mrs) Remi Tinubu	Matron
Alhaja Disu A. Abiola	Matron
Mr. Doja Taiwo	General Overseer
Mr. Olalekan Azeez	Project Coordinator

"I AM PREGNANT"

<i>Title of staff members</i>	<i>No of staff</i>	<i>Background</i>
General overseer	1 volunteer	Graduate
Project Coordinator	1 full time	U-graduate
Project Secretary	1 full time	" "
Head of pub. Relation	1 full time	Diploma
Protocol Officer	1 part time	Student
Programme Officer	1 full time	Diploma
Assistant project manager	1 full time	Diploma
Project manager	1 full time	Graduate
Performing Artists	20 volunteers	Youths.

AMUKOKO COMMUNITY PARTNER FOR HEALTH (AMCPEH)

Name of Board Members	Position
Dr. Babatunde Bosun	Chairman
Mrs. Oriola Biola	Vice Chairman
Dr. Adebambo	Project Coordinator
Mr. Adigun	Secretary
Mr. Lukeman Iyanda	Financial Secretary
Mr. Oderide Mike	Treasurer
Mrs, Labake Ayodeji	PRO
Mrs, Adigun Kudirat	WEC Chairperson
Mr. Biodun	Youth Coordinator
Mrs. Modupe Dada	Assistant Secretary.

Key informant interviews

Community Development Association Secretary
Head-teacher of perfect child nursery and primary school
Headmaster of God's Wisdom Pry. School
The Imam of Owoduni Community Mosque
The Head of Christ Apostolic Church Owoduni
Two Medical doctors
Two Nurses.

WIN officials interviewed

S/No.	Persons Interviewed	Position
1	Gloria Alaneme	Administrative Officer
2	Elizabeth Gideons	Asst. Project Co-ordinator, WIN HFB

Ministry of Health

Dr. O.G Olomolehin – Director of Primary Health Care and Disease Control

Ministry of women Affairs

Ms Salau - Assistant Director Child Development

Ministry of Youth, Sports and Social Development

Mr. Malik - public relation officer

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