



Achievements and Implications of Care and Support Programme among Orphans and Vulnerable Children: A Systematic Evaluation of HAF II Project in Bayelsa State, Nigeria

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ABSTRACT

Background: In Nigeria, children who need special protection on the account of being in vulnerable situations are observably increasing due to growing levels of poverty and the poor socio-economic situation of the country and it is necessary to ameliorate the problem by strengthening the capacity of families. This article therefore presents the achievements of care and support programme among orphans and vulnerable children (OVC) in Bayelsa State, Nigeria as well as the implications for future programming.

Methods: The project was an intervention study carried out among OVC in Bayelsa State, Nigeria. Four civil society organizations were engaged by Bayelsa State Agency for the Control of AIDS (BYSACA) under HIV and AIDS Fund (HAF) II project to provide care and support services for OVC. The target population consisted of paternal orphan or maternal orphan, double orphan and vulnerable children whose parents are infected with HIV but alive in six local government areas. A total of 3000 was an estimated sample size for this intervention and data were collected using various data reporting tools and analyzed using Microsoft Excel.

Results: The total number of OVC reached during the project period was 5410 given a target reached of 180.3%. Among these, 87.7% of the children were reached with at least one service, 74.9% were reached with psychosocial services, nutrition (37.4%), educational services (33.3%), healthcare services (9.5%) and protection services (4.4%). Thirty-five children withdrawn from the programme and two children reported died during this project.

Conclusion: Efforts to care, support and protect vulnerable children should not only focus on their immediate survival needs such as food, education, water, shelter and clothing, but also on long-term developmental needs that reduce children's vulnerability such as life skills, child protection, vocational training, food security, and household economic strengthening.

Keyword: Care and support, HAF II project, HIV/AIDS, Orphans and vulnerable children,

I. INTRODUCTION

The HIV epidemic has revealed a broad range of vulnerabilities faced by children and their families. Such vulnerabilities are especially apparent in sub-Saharan Africa, which accounts for the highest HIV prevalence in the world combined with structural risk factors, including high poverty rates, low life expectancy, high infant and child mortality, and low education levels, particularly among women and girls [1]. The latest report on orphans and vulnerable children (OVC) by the U.S. Government (USG) and partners estimated that, in

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2008, 163 million children (age 0–17 years) across the globe were orphans (referring to loss of one or both parents to all causes) and that 17.5 million of these children lost one or both parents to AIDS [2]. The global figure of 17.5 million orphans because of AIDS represents an increase from the 2007 estimate of 15 million AIDS-related orphans [3]. Moreover, children under age 15 living with HIV were two million in 2007, with 1.8 million of these children residing in sub-Saharan Africa [3]. Tragically, these numbers will continue to increase in the coming years because of the adults in the region already living with HIV and AIDS and the continuing difficulties in expanding access to life-prolonging anti-retroviral treatment [4]. In sub-Saharan, African, even more deadly than elsewhere, the HIV and AIDS have deepened poverty and increased deprivations. The responsibility of caring for orphans is a major factor in pushing many extended families beyond their ability to cope [5]. Children orphaned by HIV and AIDS are most times at disadvantaged and often devastated. For instance, in addition to the trauma of witnessing sickness and death of one both parents, they are likely to be poorer and less healthy than non-orphans [5]. They are also prone to damaged cognitive and emotional development, they have less access to education and most times subjected to the worst form of child labour [5]. There has been an increased number of OVC in Africa due to HIV and AIDS and other pathogenic causes. These death rates are getting on increase and higher among OVC. These crises have calls for programmes that can provide support and care to OVC [6]. A study also revealed that some of these intervention programmes had not offered maximum care, support and protection for OVC [7]. Approximately 16.6 million children (under 17 years of age) have lost their parents due to HIV [8]. Millions more children are vulnerable to the physical, psychological, and economic effects of HIV within their households or communities [8].

In Nigeria, children who need special protection on the account of being in vulnerable situations such as orphan hood and homelessness are observably increasing due to growing levels of poverty and the poor socio-economic situation of the country. The Core Welfare Indicator Questionnaire (CWIQ) survey [9] indicated that 0.4% of children under the age of 18 were orphans who have lost both parents. In addition, about 3.4% lost their fathers while 1.3% lost their mothers [9]. The results of the study by Ibeh [10] indicates that a vulnerable child is less likely to enroll in school, and more likely dropout of school to engage in risky sexual behaviour, and engage in substance abuse. Often such child is exposed to abuse, exploitation and social exclusion [10]. It is therefore necessary to ameliorate the problem by strengthening the capacity of families to protect and care for OVC, as well as mobilizing and supporting community based responses to increase OVC access to essential care and support services. Hence, this article presents the achievements of care and support interventions among OVC in Bayelsa State, Nigeria as well as the implication for future programming.

II. METHODOLOGY

Study Design

The project was an intervention study carried out among OVC in Bayelsa State, Nigeria. Four civil society organizations (CSOs) namely Association of Orphans and Vulnerable Children in Nigeria (AONN), Crusade for Greater Nigeria on Poverty and Social Matters (CFGN), Progress Initiative Support Group (PISG) and Royal Healthcare Foundation (RHF) were engaged by Bayelsa State Agency for the Control of AIDS (BYSACA) under HIV and AIDS Fund (HAF) II project to provide care and support services for orphan and vulnerable children. The project was implemented from April, 2016 and January, 2017.

Study Site

This project was carried out in Bayelsa State. The state has a total of eight local government areas (LGAs) and was carved out of Rivers State in 1996 which is situated in Niger Delta of the South-South geographical zone of Nigeria. It shares boundaries with Delta State on the North, Rivers State on the East and the Atlantic Ocean on the West and South. It is a picture square tropical rain forest, with a total land area of 9,656 square kilometers. More than three quarters of this (8453 square kilometers) area is occupied by waters and is predominately riverine, full of lakes, creeks, swamps and marshy land, with moderately low land stretching from Ekeremor to Brass Local Government Areas. Bayelsa State is a major oil and gas producing area and contributes to over 30% of Nigeria's oil production [11].

Target Population

The target population consisted of paternal orphan or maternal orphan, double orphan and vulnerable children whose parents are infected with HIV but alive in six local government areas namely Ekeremor, Kolga, Ogbia, Sagbama, Yenagoa, Southern-Ijaw LGAs.

Sample size

The estimated sample size for this intervention was 3000 OVC.

Description of Intervention

Advocacy

Advocacy visits, orientations, start-up seminars and mobilization were carried out during this intervention. All government, private owned and cottage hospitals were visited in the targeted communities to ensure adequate mobilisation of OVC and to strengthen the project also to ensure participation of various stakeholders. In addition, home visit was also conducted to counsel and support based on identified needs of the affected child.

Provision of educational materials

Vulnerable children were provided with educational material such as mathematical set, pen, pencil, note books, school bags, shoes, eraser etc.

Inauguration of child protection committees

Child protection committees (CPC) were formulated at the various communities where they do not exist. The CSOs also strengthened CPC in communities where they existed earlier.

Psychosocial support service

Psychosocial support services were made available for the children in form of recreational services. The activities include: dancing competition, throwing the ball, dancing round the chair, wheel barrow race and lots more. During the activities, other children in the communities that were not enrolled into the program also benefited and could freely participate in the activities.

Home visit to provide counselling support

Counselling service was provided to participants by trained volunteers on a wide-range of issues on HIV status disclosure, ART adherence, personal hygiene, eating healthy and hygienic food, coping with emotions etc. This was carried out through home visit conducted by trained volunteers across this project communities.

Linking OVC to health facility to access basic medical investigation

The vulnerable children were referred to health care facility for basic medical investigation (Malaria and HIV testing) and were followed up appropriately.

Supply of food items

As part of the integrated services rendered to children within the reporting period, the CSOs purchased and distributed nutritional food items to households who have children enrolled into the programme. The food items distributed were based on needs of each family and ensure they were basic items. The items distributed included; rice, beans, plantain, palm oil, tubers of yams, noodles, maggi, golden morn, milk and tin tomatoes.

Nutritional education

The caregivers of OVC were trained and guided on the type of foods. They were provided with nutritional education on cheaper foods that are very nutritious which should be adopted and given to the children. They were advised to use the cheaper methods to guarantee maintenance of balanced diets despite the economic situation of the country.

Basic health screening

The health status of all enrolled children were checked. Basic health screening was conducted by medical personnel engaged by each of the CSOs. The screening services included blood group, genotype, weight and height (BMI), HIV status and packed cell volume (PCV). All the tests were done with the consent of the parents/caregivers. The results were received by the parents and properly documented.

III. DATA ANALYSIS

Data were collected using various data reporting tools and were entered on DHIS2 platform. The data was later exported into and analyzed using Microsoft Excel. Data were presented using descriptive statistics such as percentage, simple proportion and frequency.

Ethical Consideration

Prior to the commencement of the project, the proposal was subjected to a two-stage review and ethical approval to conduct the research was obtained from the National and the State Ethical Review Committee, Federal Ministry of Health, Nigeria after an in-depth review of the proposal for compliance with ethical guidelines. Also, permission was obtained from the leaders of the identified groups where necessary. The criteria for selection of participants included voluntary declaration of participation in the project.

IV. RESULTS

The total number of OVC reached during the project period was 5410 given a target reached of 180.3%.

Enrollment pattern of clients

A total of 2275 and 3135 children were enrolled in the first and second quarter of the intervention respectively. The total number of children provided with at least one of the services was 4742 and among these, 56.4% were provided with service in the second quarter. Thirty-five children withdrawn from the programme and two children reported died during this project (Table 1).

Table 1: Enrollment pattern of clients

Enrollment pattern of clients	First Quarter n (%)			Second Quarter n (%)			Grand Total
	Male n (%)	Female n (%)	Total n (%)	Male n (%)	Female n (%)	Total n (%)	
Children enrolled	1225 (53.8)	1050 (46.2)	2275 (42.0)	1672 (53.3)	1463 (46.7)	3135 (58.0)	5410
Children provided at least one service	1119 (54.1)	948 (45.9)	2067 (43.6)	1422 (53.2)	1253 (46.8)	2675 (56.4)	4742
Children withdrawn from programme	18 (60.0)	12 (40.0)	30 (85.7)	3 (60.0)	2 (40.0)	5 (14.3)	35
Children known to have died	1 (100.0)	0 (0.0)	1 (50.0)	0 (0.0)	1 (100.0)	1 (50.0)	2
Children lost to follow-up	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0

Care and Support Services

A total of 516 children were provided with healthcare services and (80.2%) of these children were provided with the service in the first quarter of the intervention. On the issue of nutrition service, 2026 children were provided with the service and 61.1% were provided in the second quarter. Many (59.5%) of the children provided with educational services were provided in the second quarter of the intervention and a total of 4054 children were provided with psychosocial support services (Table 2).

Table 2: Care and Support Services

Care and Support	First Quarter			Second Quarter			Grand Total
	Male n (%)	Female n (%)	Total n (%)	Male n (%)	Female n (%)	Total n (%)	
Children provided with healthcare services	219 (52.9)	195 (47.1)	414 (80.2)	48 (47.1)	54 (52.9)	102 (19.8)	516
Children provided with nutrition services	430 (54.6)	358 (45.4)	788 (38.9)	680 (54.9)	558 (45.1)	1238 (61.1)	2026
Children provided with educational services	399 (54.7)	330 (45.3)	729 (40.5)	574 (53.5)	498 (46.5)	1072 (59.5)	1801
Children provided with psychosocial support services	960 (54.5)	801 (45.5)	1761 (43.4)	1239 (54.0)	1054 (46.0)	2293 (56.6)	4054
Children provided with protection services	0 (0.0)	0 (0.0)	0 (0.0)	129 (54.0)	110 (46.0)	239 (100.0)	239

Coverage of Intervention

Out of a total of 5410 children enrolled during this intervention, 87.7% of the children were reached with at least one service, 74.9% were reached with psychosocial services, nutrition (37.4%), educational services (33.3%), healthcare services (9.5%) and protection services (4.4%) (Fig.1).

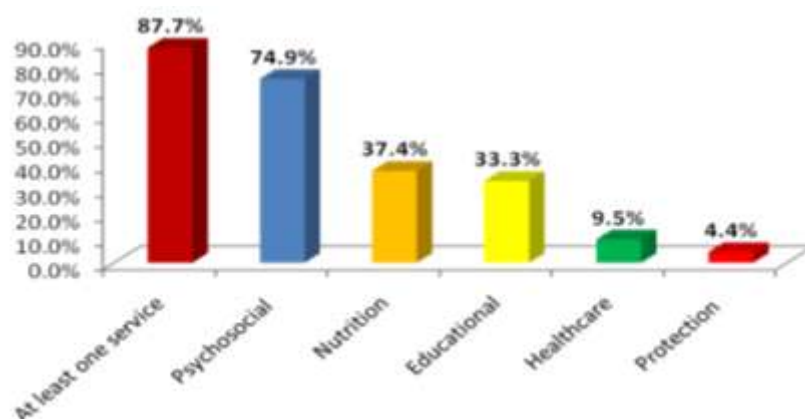


Fig. 1: Coverage of Intervention

V. DISCUSSION

Only few of the children accessed healthcare services during this intervention. This may be attributed to the fact that most of the children have no health constraints at the time of the project. This is quite encouraging but this finding is different from the findings of the health status of OVC in Cameroon which revealed that 90% of them had one health problem or the other while another study carried out among children in Zimbabwe showed that OVC were more likely than non-orphans to have recently suffered from diarrheal disease and acute respiratory infections and they were also more likely to be stunted [12-13]. Many of the children enrolled in this project were provided with nutritional support. A survey carried out in Nigeria revealed that more than a quarter of the children studied showed symptoms of mild to moderate malnutrition such as weight loss. Even worse, 66.7% of them were experiencing household food insecurity putting more of them at risk of malnutrition. This finding is not surprising since more than half of the respondents (57.9%) lived in households with no source of income apart from subsistent farming [14]. This situation is similar to that of OVC in Cameroon where more than a third of the OVC families needed income-generating activities to support the children [15]. A larger proportion of the children were provided with psychosocial services. This is similar to what was reported by Adelekan et al., [16] in a similar project in Kogi State in Nigeria. Healthy child development depends a great deal on the continuity of social relationships and the development of a sense of competence. HIV/AIDS can undermine the fundamental human attachments essential to normal family life and child development. Children affected by HIV/AIDS suffer anxiety and fear during the years of parental illness, followed by grief and trauma with the death of a parent [17]. Cultural taboos surrounding the discussion of AIDS and death often compound these problems. Children and their caregivers need love and emotional support, and the opportunity to express their feelings without fear of stigma and discrimination [17]. Only a quarter of the children were provided with education service. This is lower than the proportion of children provided with educational access in a similar study in Kogi State, Nigeria [16]. Research on children and AIDS demonstrates that education can leverage significant improvements in the lives of orphans and other vulnerable children [18]. Schools not only benefit the individual child, but can also serve as important resource centers to meet the broader needs of communities. Schools can provide children with a safe, structured environment, the emotional support and supervision of adults, and the opportunity to learn how to interact with other children and develop social networks. An education is the key to employability and can also foster a child's developmentally important sense of competence. Countries and communities must identify the barriers to education (e.g., requiring a father to register a child, mandatory payments for uniforms, book or tuition fees) and define locally-appropriate strategies for attracting and keeping children, especially girls, in school. Programs must give special attention to the vulnerability of girls, by addressing the disproportionate levels of risk they face when leaving school at an early age. Schools must also be made safe for children, especially girls. In addition, vocational training is an important component of life preparation. Conversely, the lack of opportunity to learn a trade or the lack of a sponsor to enter vocational networks can compromise an adolescent's long-term economic prospects [17].

Implications for Programming

Orphans and vulnerable children often face an immediate crisis in the home. Meeting their immediate needs is vital to their current well-being but is also critical to their future. Basic or "core" needs include food/nutrition, shelter and care, protection, health care, psychosocial support, and education. Illness in the family or the loss of a parent or parents is extremely disruptive for children, and often seriously disadvantages their chances for obtaining basic living needs as well as for securing a place in school or future employment. Financial and material resources are often required to meet most of these needs, so economic strengthening is

essential. Government and implementing partners need to ensure essential core support is available to identified OVC. At the child level, the six core areas of a child's life (food/nutrition, shelter and care, protection, health care, psychosocial support, and education) and the means to maintain them (economic strength) should be regularly monitored. Comprehensive, quality services should then be designed to meet each child's specific needs. Future programs should provide age-appropriate prevention activities for OVCs, including PMTCT intervention, as well as communication for behavior change targeted to appropriate age groups. OVC programs need to ensure vulnerable children get age-appropriate effective HIV prevention messages, including abstain, be faithful, and, as appropriate, correct and consistent use of Condoms (ABC), as well as avoiding injecting drugs and alcohol abuse. This is particularly true for programs that target adolescents and older youth.

VI. CONCLUSION

Efforts to care, support and protect vulnerable children should not only focus on their immediate survival needs such as food, education, water, shelter and clothing, but also on long-term developmental needs that reduce children's vulnerability such as life skills, child protection, vocational training, food security, and household economic strengthening.

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