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Evaluating the Effectiveness of Case Management of Vulnerable Children at Household Level in Delta State, Nigeria

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ABSTRACT

Poverty, war, HIV/AIDS, traffic accidents, infectious and non-communicable diseases, and detrimental cultural customs are the main causes of orphaning and vulnerability. Therefore, the case management approach has been adopted as a community service delivery technique to address the needs of vulnerable children and orphans at the family level. This study assessed the case management approach's efficacy in delivering household-level services to vulnerable children, orphans, and their caregivers in Delta State, Nigeria. An explanatory case study design using a mixed method of both quantitative and qualitative study were used to analyze descriptive variables and indicators that evaluates the outcomes of services provided to vulnerable children and their caregivers using the case management model. Data from quantitative surveys from vulnerable children national service provision tools were analyzed to obtain the outcome of services received from Orphans and Vulnerable Children and their Caregivers. Conversely, a semi-structured qualitative questionnaire was administered to key stakeholders of orphans and vulnerable children programs including CBOs/NGOs, Government Officials, Case Managers and relevant agencies. A total of 49,141 beneficiaries residing in some13,445 families were served across all four OVC domains–Healthy; Safe; Schooled and Stable — this exploratory analysis can rightfully argue that the case management strategy has demonstrated immense power to shape how services provided through VC programs are delivered. After being enrolled, services were provided to the households and a significant number of them moved from vulnerability to self-resilience. Findings also show appreciable levels of coordination both between government stakeholders and implementing partners within the geographical areas to strengthen systems for the provision of services needed by VCs and their caregivers. On the other hand, the results showed that vulnerable children (VC) officials from the state and local governments were not adequately working together, which hindered their ability to oversee VC initiatives. The overall results showed that case management of vulnerable children and their caregivers is an effective strategy for providing need based appropriate services to vulnerable groups and adequate synergy among critical stakeholders with increased funding is key to program sustainability as shown by this study.

Keywords: Orphans, Vulnerable Children (OVC), HIV/AIDS, Case Management, Caregivers, Community, Organizations, Health, and Government.

INTRODUCTION

Nigeria is facing an unprecedented increase in the number of Orphans and Vulnerable. In Nigeria, about 17.5 million kids were thought to be orphans and at risk in 2008 [1] and needing social services and basic care. For this study, the terms Orphans and Vulnerable Children (OVC) and Vulnerable children will mean the same. Besides poverty, accidents on roads, wars, and illnesses, HIV/AIDs is seen as a leading cause of orphanhood and vulnerability. Stigma and discrimination have been reported from HIV/AIDS affected households in all aspects of lives [2]. They are socially ostracized within their communities and striped off their rights and dignity. They are required to work the extra harder and surpass the social hurdles to provide for basic household need such as food, school fees and basic health care. The Objective of orphans and vulnerable children (OVC) programming is to build the resiliency of families and children affected by HIV and AIDS so that they can meet their health, economic, education, and social development needs. With regards to Lantos-Hyde Act [3], 10% of PEPFAR funding is to be allocated to children affected by HIV and AIDS (Lantos, 2016). Overtime, case management has been adopted as a strategic approach of addressing the needs of vulnerable children and their households especially those infected or affected by HIV/AIDS (4Children, 2017). Case Management is a process adopted by social service delivery providers usually targeted at vulnerable children and families. The goal of case management is to enable children and households to achieve a state of well-being in which they are stable and secure enough to meet their needs which includes social, financial, protection, emotional, health and education needs. This will make them resilient to withstand modest shocks [4]. This research examines the services provides to identified vulnerable households enrolled into OVC programs using case management approach as well as investigating the impact and effectiveness of the OVC Program in Delta state.

General Objective

To evaluate how well the case management approach works in Vulnerable Children (OVC) Programs.

Specific Objectives:

1. To Evaluate the effectiveness of the Vulnerable Children (VC) Case management approach.
2. To examine the outcomes of VC case management interventions
3. To identify the limitations of case management processes

Research Question

1. How effective is the VC case management approach?
2. What are the outcomes of VC case management interventions?
3. What are the limitations of case management processes?

Statement of the Issue

It cannot be overemphasized that children and families in Nigeria and sub-Saharan Africa by extension, lack basic necessity and support for optimum development. The estimated number of children in Nigeria who are orphans, vulnerable and in need of essential care was 17.5 million [1]. Major causes of orphaning and vulnerability include poverty, conflicts, HIV/AIDS, road accidents, communicable and non-communicable diseases and harmful cultural practices etc. Hence, the need to adopt best practices and cost-effective approach to addressing the basic

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need of orphans & vulnerable children and households affected or infected by HIV/AIDS. In recent times, international donors, especially The US President's Emergency Plan for AIDS Relief (PEPFAR), have adopted case management as the most productive approach of addressing the basic needs of vulnerable children and their caregivers while achieving HIV epidemic control and enabling beneficiaries attain self-resiliency. It is therefore imperative to investigate the effectiveness of the case management approach, highlighting challenges, bottles necks and appropriate solutions while identifying valuable lessons in achieving the sustainable development goals.

Overview of Orphan and Vulnerable Children Program in Nigeria

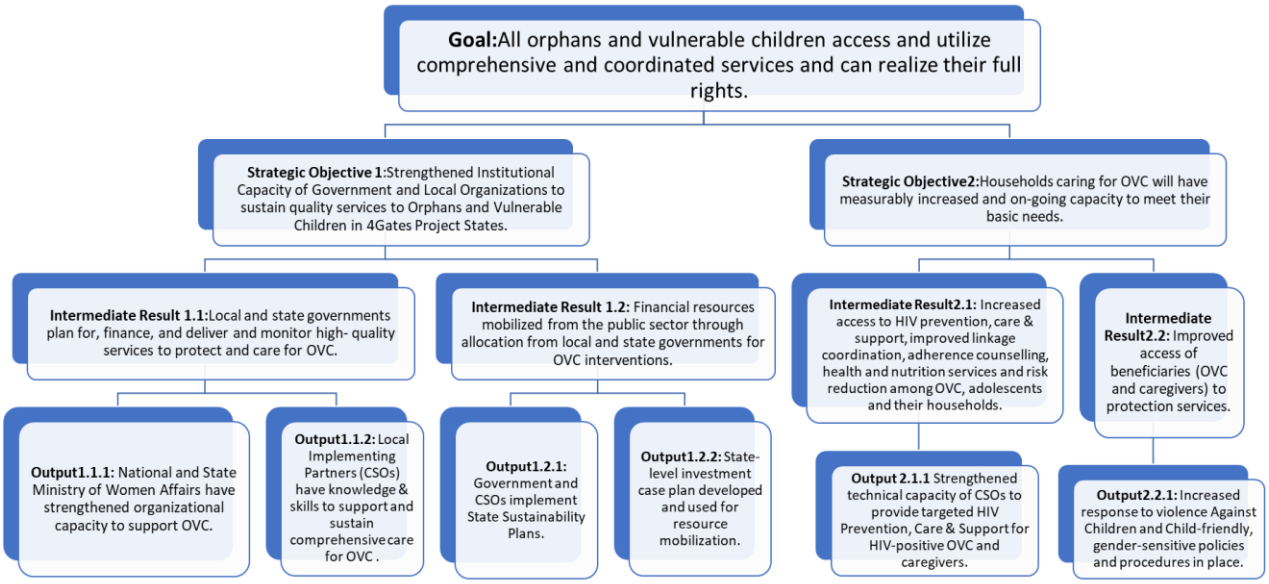
An orphan is defined as a child under the age of 18 years whose mother (maternal orphan), father (paternal orphan) or both (double orphan) are dead [5]. A vulnerable child is one who is living in circumstances with high risks and whose prospects for continued growth and development are seriously threatened. A vulnerable child is exposed to abuse and too young to fight for his/her Rights (e.g. dis-inheritance, education).

A child is defined as boy or girl under the age of 18 years according to the National Plan of Action on Orphans and Vulnerable Children in Nigeria (2007) [6]. An orphan on the other hand is a child (below the age of 18) who has lost one or both parents, irrespective of the cause of death. Those who have lost both parents are commonly referred to as "double orphaned". The definition of vulnerability differs from society to society; therefore, definitions are community specific. However, the Federal Ministry of Women Affairs (2007) [6] provides some key indicators defining children's vulnerability including children that are: Children from broken homes, Neglected children, Child beggars, destitute children and scavengers, Children with physical and material disabilities, Internally displaced children, Abandoned children, Children who have dropped out of school. Orphans and vulnerable children (OVC) require certain structured social services which include but not limited to: care and support services, household economic strengthening, clothing, shelter, emotional and psychosocial support, water sanitation and hygiene, recreation, and life building skills [6]. The goal of OVC programming is to build resiliency for families and children affected by HIV and AIDS, enabling them to meet their health, economic, education, and social development needs. In Nigeria, as at 2008, there were 17.5 million orphans, vulnerable, and in need of essential care. Major causes of orphaning include poverty, conflicts, HIV/AIDS, road accidents, communicable and non-communicable diseases, and harmful cultural practices. Case management is a strategic approach to address the needs of vulnerable children and their families, aiming to achieve a state of well-being and resilience [4]. The United State Government through PEPFAR funds OVC is a programs, which focuses on children who have lost a parent to HIV and AIDS, are directly affected by the disease, or live in high HIV prevalence areas. The program aims to reach the most vulnerable children to mitigate the impact of HIV and prevent new infections. Factors contributing to child vulnerability include poverty, urbanization, insecurity, insurgency, HIV/AIDS effects, and socioeconomic changes [3]. In Nigeria, 40% of citizens live below the poverty line, with 40.7% being children aged 0-14. Over half of Nigerians live in multidimensional poverty, lacking access to basic amenities. Around 68% of children aged 0-17 are multidimensionally poor [7][8].

As of June 30, 2023, 3,578,996 Nigerians were internally displaced due to civil conflicts, insurgencies, and environmental factors [10]. Women and children are the most affected, with

130,000 children living with HIV in Nigeria. In 2020, 20,695 children and 6,479 adolescents were newly infected with HIV, with teenage girls being disproportionately affected. AIDS-related causes account for almost 30% of AIDS-related deaths. The number of vulnerable children has increased from 7 million in 2003 to 17.5 million in 2008. The government, development partners, and other stakeholders have worked to protect children's rights, including the Child Rights Act, the VC division, and the National Plan of Action. Notable publications include the 2007 National Guidelines and Standards of Practice on Orphans and Vulnerable Children. [9] [10].

Theoretical Result Framework for Vulnerable Children Response



Case Management Processes in OVC Programs

In the context of OVC programs, case management can be referred to as the process of identifying vulnerable children and families; assessing their needs and resources; working together to establish specific, realistic objectives and goals and planning actions to achieve objectives and goals; implementing plans through completing specific actions and receiving services; monitoring both the completion of actions (including the receipt of services in a timely, context sensitive, individualized, and family-centered manner) and progress toward achievement of objectives/goals (e.g., child protection and well-being, including HIV prevention, treatment, and adherence). Implementing agencies and organizations usually recruit and train case workers sometimes called community volunteers or case managers to execute the implementation of OVC Program interventions (4Children Case Management SIMS).

Critical Steps of Case Management

There are seven steps in the case management process which are highlighted in Figure 1.

Step1: Identification of Eligible Households:

This is a process of identifying children orphaned, affected, or made vulnerable by HIV/AIDS and other adversities and their caregivers, and referring them for further eligibility verification

and assessment. Community Based Organizations establish and document procedures for identifying orphans and vulnerable children through multiple entry points and referring them for screening and program enrolment (PEFPAR Guidance for Orphans and Vulnerable Children Programming, 2012). Potential and eligible beneficiaries usually exceed those who can receive OVC services based on availability of resources. A standard procedure, intake tools and forms will ensure fair and unbiased criteria are adopted to identify appropriate clients, rapidly assess their vulnerabilities, and determine their eligibility to benefit from enrolment in an OVC program [11].

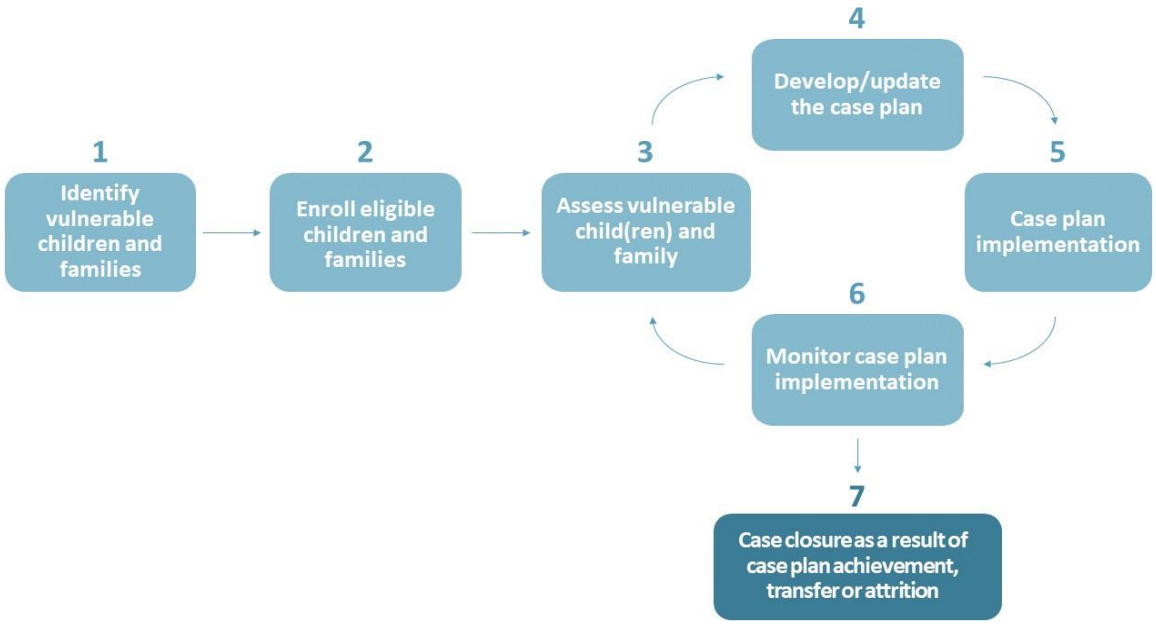


Diagram Showing the OVC Case Management Processes

Step 2: Screening and Enrolment of Eligible Households:

HIV bias is often present in eligibility criteria for screening and prioritizing children and careers for enrolment in Orphans and Other Vulnerable Children (OVC) programs. These criteria are based on available data and are determined by stakeholders, such as program implementers, government representatives, and community members. Standardized methods are used to establish eligibility criteria, expectations, and thresholds for protection and well-being. Children living with HIV, those living with an HIV-positive adult, teenage girls at risk of engaging in transactional sex, children orphaned by AIDS, and children experiencing violence or abuse are the main requirements for enrolment. Other vulnerability criteria include chronic illness, loss of parents, poor nutrition, irregular school attendance, poor psychological state, substandard housing, access to clean drinking water, and not engaging in economic strengthening activities. Screening results are sent to decision-making bodies to ensure program objectivity and accountability. Upon enrolment, children and caregivers are assigned case managers, who open family files containing beneficiaries' information. Consent from household health or caregivers is sought and documented before enrolment.

Step 3: Household Assessment:

The case management process involves identifying the resources and needs of children and their families, using tools to evaluate resources and address primary needs. Assessments

typically include socioeconomic status, health, nutrition, HIV status, shelter, psychosocial well-being, education, and protection [12]. Quantifiable markers like weight, height, and upper arm circumference are used, while qualitative data is gathered from various sources. Assessment instruments must be tailored to the program and environment, considering cultural, regional, and socioeconomic circumstances [13]. Specialized tools may be required to evaluate economic vulnerability, health, nutrition, developmental delays, and child protection risks. Data from assessments is used to create a well-understood case plan or customized household care plan. Reassessment is not a one-time event due to the complexity of the problems faced by vulnerable children and caregivers [14] [15].

Step 4: Household Care/Case Plan Development:

This is the process of determining objectives for a child and family as well as the precise steps necessary to reach those objectives. Priority action would entail creating a documented plan that includes objectives, tasks, accountability for tasks, a timeline for carrying out tasks, and metrics to gauge the success of tasks [16]. A case plan in the framework of President's Emergency Plan for AIDS Relief (PEPFAR) OVC programs typically focusses on the entire family (sometimes called a household but understood to include the primary caregiver(s) and all children); however, the family care plan may contain separate subplans that concentrate on specific children and caregivers.

Step 5: Household Care Plan Implementation:

This is the process of appropriately and promptly completing the steps outlined in the prepared care plan. The priority activities entail providing children and carers with direct, targeted services or assistance so they can take independent action. It also entails sending a kid or carer to a particular provider to help them finish tasks specified in the care plan. Children and carers themselves could accomplish priority tasks like going to school on a regular basis or taking their medications on time. Additionally, actions can be carried out with the help of the manager or case worker and/or by receiving certain services, such financial skills training, parenting skills training, nutrition assessment, or joining a savings club [17]. Services can be offered by the case worker, the organisation, or another organisation that the case worker refers children and carers to. Examples of these include HIV testing and health services offered by clinics or statutory services supplied by government agencies. Programs are not inherently equipped with the knowledge or resources to offer every service a client could need. Referrals to other organisations can guarantee that clients receive high-quality services that are unavailable within the case manager's organisation but necessitate extra follow-up and coordination to guarantee that services are received, are of the highest calibre, and produce the intended results [18]. The creation of a Memorandum of Understanding (MOU) committing to particular protocols for tracking and managing referrals and sharing client information while maintaining confidentiality, the creation of standardised tools and resources to facilitate referrals, the identification of specific Referral Focal Points, and an initial mapping of the services that are available may also be necessary for managing referrals.

Step 6: Monitoring of Household Care Plan Implementation:

The case management process involves scheduling meetings with the child and carer, family members, service providers, and other stakeholders to assess the progress of the care plan's implementation and the likelihood of reaching predetermined goals. Regular home visits are crucial to determine if the care plan is being implemented successfully. Monitoring frequency

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may vary depending on the necessary treatments and support level. Case workers must visit a child and carer at least once every three months to be considered an "active beneficiary" under the OVC program. They should also monitor home visits to detect changes in the child or caregiver's condition through observation and interviews. Documenting visits and making necessary adjustments to the care plan is essential. Frequent case conferences with service providers can help coordinate help and exchange information. Regular reassessments are necessary to determine a child's or caregiver's new requirements, priorities, and resources. Verifiable consent is required for any modifications to the case plan [19].

Step 7: Household Care Plan Achievement and Case Closure:
The final step in case management involves closing case files when a child or household leaves the OVC program due to completion of a care plan, transfer, or attrition. Prioritizing documentation of the departure process is crucial. Programs should have established procedures for these pathways. [4].

Step 8: Case Plan Achievement:
Case plan achievement in OVC programs refers to the completion of suggested activities and interventions, meeting both program goals and household goals. Graduation, often used in poverty reduction initiatives, can also describe case or care plan achievement. Success does not mean households no longer need assistance; it means carers demonstrate ability to meet children's needs or children no longer require intervention. Processes include assessment, planning, monitoring, and final review and ceremony.

Step 9: Household Transfer:
In some cases, a child or household may not complete their case plan or graduate from an Out of Home Care (OVC) program. This can lead to a transfer of case management and service responsibilities to another support system. This transfer occurs at the case level and is not the same as transition, which involves local support taking over responsibility for a community's overall OVC response. Transfer pathways may involve identifying ongoing household needs, locating additional support organizations, negotiating agreements with service providers, enhancing preparedness, pre-transfer planning, facilitating client introduction, transferring case files, and following up.

Step 10: Attrition:
Attrition in OVC programs occurs when interventions or assistance for a child or household end due to events outside the program's control, such as a child's death, caregiver's removal, or failure to follow participation agreements. Attrition cases should be verified and recorded, and cases are typically closed in digital or physical file storage systems. After closure, the project no longer actively supports or monitors the home, allowing fresh OVC households to be enrolled through ongoing initiatives.

METHODOLOGY

The study employs a mixed method study design. [20] explained that mixed methods research combines quantitative and qualitative research in other to answer research questions. Tegan further purposed that the mixed methods were implied to help researchers gain more insight and complete picture than a standalone quantitative or qualitative study. This enabled the integration of the benefits of both methods.

Quantitative research methodology underscores objective measurement and mathematical, statistical and numerical analysis of data collected through questionnaires, polls and survey or by manipulating pre-existing statistical data using computational techniques [21]. Quantitative research is deductive and focuses on collecting numerical data and generalizing it across groups of people or to explain a particular phenomenon [22]. For the quantitative aspect of this study, the researcher utilized pre-existing data, collected with National OVC Management Information System tools to evaluate real time progress of OVC Programs and investigate the effectiveness of the case management approach used in the service delivery of OVC interventions. The researcher evaluated the 20 standard OVC indicators to measure achievement and progress of OVC intervention across the state [23]. Creating information and understanding of the social ecosphere is the aim of quantitative research. Social scientists, public health researchers, and communication researchers employ quantitative research to investigate conditions or phenomena that have an impact on people. The sample population is a specific social group that can be studied through quantitative research. Quantitative research uses measured or observed data to investigate questions about the sample population through systematic inquiry [24].

Conversely, the researcher also adopted qualitative research design to provide a robust explanation for quantitative data. Usually, qualitative research designs are more flexible than quantitative ones as they promote a close relationship between the researcher and the respondents and are generally bottom-up and inductive. Qualitative researchers collect data in the form of written or spoken language, or observations that are recorded in language, and they analyze the data by identifying and categorizing themes, [25] explains that qualitative research is naturalistic, holistic and inductive. Inductive, qualitative research studies phenomena as they unfold in real-world situations, without manipulation, as interrelated wholes rather than splitting them up into discreet predetermined variables [26]. Since this study investigates the OVC programme at household level, as well as how the programme affects OVC's family wellbeing, this research is naturalistic and holistic. The questions posed to solicit information enabling further deliberation by respondents (key OVC stakeholders) and thus allowed the researcher to uncover important information on the topic. The study is also exploratory in nature. Exploratory studies are open and flexible. They adopt an inductive approach as the researcher makes a series of observations and attempts to patch these together to form more general but speculative hypotheses, resulting in explanations of what is observed [27]. This study thus investigates the effectiveness of the OVC programme at the household level by engaging various actors involved in the realization of its objectives. The investigation took the form of a case study, with seven Community Based Organization (CBOs) and NGOs dealing with HIV/AIDS implementing OVC programmes across Delta state. According to [28], case studies are intensive investigations of particular individuals or cases. They may also involve the study of single families, units (e.g., hospital wards), organizations (e.g., NGOs dealing with HIV/AIDS), communities (e.g., an informal settlement) or social policies [29].

Ethical Consideration

Ethical approval was also received from Atlantic International University ethical committee. Consent was also be sought from Community Based Organization's conducting OVC Programs in Delta state who have hitherto received consent from their beneficiaries. This study respected human dignity in the cause of its activity and analysis and did not cause any harm.

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RESULTS

Evaluation of the outcomes of achievement of OVC Custom Indicators for services provided to vulnerable households in Delta State within the last 2 years.

OVC_SERV - Number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV by LGAs in Delta State disaggregated by sex for vulnerable children and caregivers.

Delta	Male	Female	Total
Grand Total	19,201	29,940	49,141

OVC_SERV - Number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV by LGAs in Delta State for vulnerable children and caregivers.

Delta	Vulnerable Children	Caregivers	Total
Grand Total	35,696	13,445	49,141

Table 9: Education level of Vulnerable Household/Caregivers that received OVC Services.

Education level	Freq	Percent	Cum.
Completed Secondary Education/High School	1,153	8.58	8.58
Completed Primary Education	2,211	16.44	25.02
Completed Tertiary Education	176	1.31	26.33
No Formal Education	339	2.52	28.85
No-information	4,849	36.07	64.92
Prefer Not to Say	2,857	21.25	86.17
Some Primary Education	778	5.79	91.95
Some Secondary Education	1,082	8.05	100.00
Total	13,445	100.00	

Economic Occupation of Vulnerable Households/Caregivers that received OVC services.

Occupation	Freq	Percent	Cum
Formally Employed	258	1.92	1.92
Informally Employed	906	6.74	8.66
No-information	4,128	30.70	39.36
Retired non-pensioner	19	0.14	39.50
Retired Pensioner	25	0.19	39.69
Self Employed	6,067	45.12	84.81
Unemployed	2,041	15.19	100
Total	13,445	100.00	

Percentage of orphans and vulnerable children (<18 years old) with HIV status reported to implementing partner disaggregated by LGA (OVC_HIVSTAT).

	Current HIV Status				
Delta	Negative	Positive	Unknown	TNR	Grand Total
Total	33,829	1,615	225	27	35,696

OVC_HIVRISKASS - #OVC <18 Years who were of unknown HIV status or HIV-negative, risk assessed using a HIV Risk assessment tool and number identified to be at Risk of HIV infection

Child at risk			
Sex(M/F)	No	Yes	Total
F	1,330	7,533	8,863
M	1,227	6,759	7,986
Total	2,557	14,292	16,849

OVC_HTSLINK- % (#) of OVC with Unknown or Negative HIV status referred for testing who got tested and received result

Delta	Frequency	Percentage	Cumm.
Total	13,144	100	100

OVC_ARTSUPP-'% self- or caregiver-reporting adherent to treatment for the last six months within the reporting period.

Delta	No	Yes	Grand Total	% Achieved
Grand Total	1582	33	1615	98%

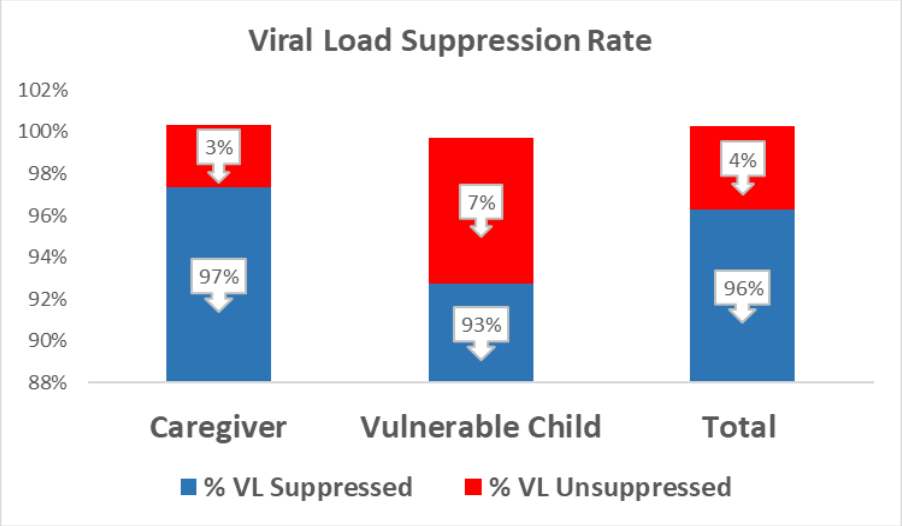
OVC_NUTRITION - % of malnourished OVC linked to appropriate Nutrition services (disaggregated by Type: Clinical; Counseling; Others)

Total Number of OVC Assessed for Nutrition	Total Number of Vulnerable Children Identified to be Malnourished	Total Number of Malnourished Children who received direct or referred services (OVC_NUT)
23642	32	30

OVC_BIRTH CERT - Percentage of Vulnerable Children receiving OVC services with birth certificates

	Freq	Percent	Cum
No	99	0.28	0.28
Yes	35,747	99.72	100.00
Total	35,846	100.00	

% Total HIV Positive beneficiaries with Suppressed Viral Load



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GENERAL DISCUSSIONS AND CONCLUSION

This study assessed the impact of case management on the Vulnerable Children (VC) program in Delta State, Nigeria. Over 49,141 beneficiaries from 13,445 households were served across four domains: Healthy, Safe, Schooled, and Stable. The case management strategy significantly influenced the program's service delivery. The study found that the Global Action for the Eradication of HIV in Sub-National Units OVC initiative in Delta state demonstrated the efficacy of the case management process. The state's care and support services, educational and psycho-social services, nutrition and health services, child protection services, and household economic strengthening services were all beneficial to vulnerable children and their caregivers. Case management is considered the most effective way to meet the basic needs of vulnerable children and their caregivers while controlling the HIV epidemic and empowering recipients to become self-resilient. The United State Government's PEPFAR funds HIV/AIDS programs and interventions, focusing on children who have lost a parent to HIV or live in high HIV prevalence areas. Orphans and Vulnerable Children (OVC) programs aim to reach children most vulnerable to HIV infection to mitigate its impact and prevent new infections. Nigeria has the highest percentage of children and adolescents aged 0-19 living with HIV in West and Central Africa, with 130,000 children living with the virus in 2020. The government, development partners, and the Association of Orphans and Vulnerable Children (AONN) have been working to preserve and protect children's rights, particularly those of vulnerable children [30]. NGOs play a pivotal role in alleviating the Plight of OVC in Nigeria, providing psychosocial support, care, and protection services, succession planning, and writing national and international policies promoting the rights of orphans and vulnerable children. However, there is a lack of coordination between VC officials from state and local governments, which limits their ability to supervise VC initiatives. The success of OVC initiatives in Delta State and throughout Nigeria depends on sufficient financing and government support.

Recommendations

1. The state's OVC program should have a larger budgetary allocation, and the government should actively work to keep an eye on how these monies are being used during project implementation.
2. OVC stakeholders, including the state technical working group and the coalition of civil society leaders, meet on a regular basis to discuss important issues impacting OVC and develop a communique and practical action plan to address their predicament at the state and national levels.
3. To improve the anticipated results of OVC programs, a strong legislative and policy framework should be implemented to enhance the delivery of OVC services at all levels of government.
4. To raise awareness of OVC initiatives in the states, advocacy and resource mobilization tactics had to be updated. The government and civil society should use the media to spread messages about OVC.
5. To improve the sustainability of program accomplishments, the ability of religious and community leadership structures should be reinforced to allow society to take ownership of OVC programs.
6. Grant distribution for OVC initiatives should be reviewed by foreign funders. It is noted that a lack of funding limits the number of beneficiaries and services offered; if funds are still available, the duration of OVC initiatives should be prolonged as well

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