A SITUATIONAL ANALYSIS OF ORPHANS AND VULNERABLE CHILDREN IN EIGHT STATES OF NIGERIA

CONDUCTED BY CATHOLIC RELIEF SERVICES AND CATHOLIC SECRETARIAT OF NIGERIA

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Dedicated to the Volunteers who give the very best of themselves to their neighbors every day.

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LIST OF ACRONYMS

ACRWC	**African Charter on Rights and Welfare of Children**
AIDS	**Acquired Immune Deficiency Syndrome**
ART	**Anti Retroviral Therapy**
CAN	**Christian Association of Nigeria**
CANACA	**Christian Association of Nigeria Action Committee on AIDS**
CBO	**Community Based Organization**
CCL	**Children in Conflict with the LAW**
CEDC	**Children in Especially Difficult Circumstances**
CNSPM	**Children in Need of Special Protection Measures**
CRA	**Child Rights Act**
CRC	**United Nations Convention on the Rights of Children**
CRS	**Catholic Relief Services**
CSN	**Catholic Secretariat of Nigeria**
CWIQ	**Core Welfare Indicator Questionnaire**
FGD	**Focus Group Discussion**
FMWA	**Federal Ministry of Women Affairs and Social Development**
HIV	**Human Immunodeficiency Virus**
HTTP	**Harmful Traditional Practices**
JDPC	**Justice Development and Peace Commission**
KII	**Key Informant Interview**
LGA	**Local Government Authority**
MICS	**Multiple Indicator Cluster Survey**
NACA	**National Action Committee on AIDS**
NDHS	**National Demographic Health Survey**
NGO	**Non Governmental Organization**
NPC	**National Population Commission**
OVC	**Orphans and Vulnerable Children**
PACA	**Parish Action Committee on AIDS**
SPSS	**Statistical Package for Social Sciences**
SRH	**Sexuality and Reproductive Health**
STI	**Sexually Transmitted Infections**
SUN	**Scale Up the Nigeria Faith-Based Response to HIV/AIDS**
UNAIDS	**United Nations Programme on HIV & AIDS**
UNICEF	**United Nations Children's Fund**
UBE	**Universal Basic Education**
VCT	**Voluntary Counselling and Testing**
WHO	**World Health Organization**

EXECUTIVE SUMMARY

The number of children orphaned from all causes in sub-Saharan Africa is expanding and has risen by more than 50 per cent in the recent time. Many African children are also made vulnerable by poverty, conflict and gender inequality. Despite the fact that Nigeria has one of the highest burdens of orphans and vulnerable children (OVC) in the world, lack of empirical data on their conditions has hampered the development of effective policy and programs to address the specific needs of OVC in the country. To meet the need for reliable data on prevalence, pattern, conditions and severity of OVC as well as to provide benchmarks for SUN/OVC project, the ***Catholic Relief Services (CRS)/Nigeria*** conducted a situation analysis of OVC in eight states in Nigeria between January and March of 2007.

The study used a multi-stage stratified probability sampling method to select 2580 households from 24 communities in 8 states, namely: Benue, Edo, Nassarawa, Niger, Kaduna, Kogi, Plateau and FCT. Data were collected by both qualitative and quantitative methods using 8 different instruments. A total of 2580 caregivers and 3086 children aged 6-17 years were systematically selected as respondents for structured questionnaires (quantitative data) while 27 focus group discussions were held with four distinct groups, including OVC aged 9-12; OVC aged 13-17; street (homeless) children aged 9-17 and; caregivers of OVC. Thirty-one key informant interviews were also held with community leaders, religious leaders and OVC-related services providers. Statistical Package for Social Scientists (SPSS version14) was used for the data entry and analysis.

A census of all children in the selected households showed that there was an average of 4 children per household, ranging from 4.6 children per household in Niger state to 3.2 children per household in Kogi state. The data revealed that 28% of all the children were orphans, 23% were single orphans and 5% were double orphans. There was a wide variation in prevalence of orphan-hood across the states, with Benue having the highest rate (40%) and the FCT with the lowest rate of 14%. Among the children selected for interview, six categories of OVC were identified, including: children that had lost one parent (24%); children that had lost both parents (8%); children whose parent(s) was/were chronically ill (4%); children living in households where a chronically ill adult died recently (1%); children living with old frail grand parents or guardians (1%); and children with disabilities (7%).

The data showed that 86% of the children interviewed were currently attending school while 14% were not attending school (5% were never in school while 9 % dropped-out of school). Further analysis revealed that children in rural communities were more educationally disadvantaged compared to their counterparts in semi-urban and urban communities. Older children (13-17 years) had less access to education than the younger children (6-12 years) but, there was no significant difference between boys and girls in term of access to education. The data also showed that non-orphans had better access to education than the orphans. After death of parents, double orphans and paternal orphans were more likely to drop out of school or record a drop in school attendance than single and maternal orphans. Among other categories of vulnerable children, children living with disabilities had the least access to education.

More than three-quarter (76%) of the children reported that they fell sick in the last three months. The major cause of illness was malaria. During the last episode of sickness, close to one-quarter (22%) of the children accessed treatment from patent medicine store/chemists,

16% received treatment from private hospitals, 10% were treated at the government hospitals while 13% did not receive any treatment. Children in the urban communities appeared to have better health status than semi-urban and rural children. Although, there was no significant gender variation in the proportion of children reported sick in the last 3 months, more females reported very good health status than males. The study also revealed that there was no significant difference in the health status of orphans and non-orphans but, higher proportion of non-orphans rated their own health status as "very good" than the orphans. Furthermore, paternal orphans were more likely to fall sick, more likely to have problem of poor health status and, more likely to report less access to health care services after the death of their father than the maternal orphans.

A fifth (20%) of the children identified insufficient food as the major problem confronting them. Children in the rural areas appeared to have a better food intake than children in urban and semi-urban areas. The data on food intake of boys and girls did not show any significant difference, but the girls had slightly better nutritional intake index than boys. The data also showed that younger children were more likely to eat 3 times a day and less likely to have problem of insufficient food than the older children. Non-orphans were more likely to eat at least 3 times daily, more likely to take protein regularly, more likely to eat food to satisfaction and less likely to report insufficient food as a problem than the orphans. Paternal orphans were less likely to eat 3 square meal daily, less likely to take protein regularly and less likely to eat to satisfaction always than maternal orphans.

In assessing the emotional and psychological wellbeing of the children, the data showed that urban children were more likely to exhibit emotional and psychosocial problems than rural children. Although the difference was not significant, girls were more likely to exhibit emotional and psychosocial problems than boys. The data further showed that orphans were significantly more likely to have emotional and psychosocial problems than non-orphans. For most of the emotional and psychosocial indices, double orphans were more likely to exhibit negative emotional tendencies than single orphans. Among the single orphans, paternal orphans exhibited emotional problems more often than maternal orphans.

The data on child rights and protection revealed that a third (33%) of the children had worked for money and 22% of the children had worked for food or other gift items. Close to three-quarter (73%) of the children had no birth certificates and 28% of the children could mention the day, month and year of their births. Incidence of forced labour was higher in semi-urban areas than rural and urban areas. Almost in all cases of child rights and protection that were examined, the data showed that boys were more vulnerable to abuse than girls**.** The data also showed that older children were more likely to be abused and forced to work for food or money than the younger children. Orphans were significantly more vulnerable to abuse and exploitation than non-orphans. Among the orphans, double orphans were more likely to have worked for money, worked for food/gifts, forced to engage in economic activities and less likely to know their dates of birth than the single orphans. Paternal orphans were the second most vulnerable group (after double orphans) in terms of child labour and abuse of rights.

About two-third (67%) of the children had heard of HIV & AIDS. An assessment of the attitudes of the children towards people living with HIV & AIDS showed that only 29% of the children were willing to eat with a person living with HIV & AIDS. Knowledge of modes of transmission of HIV &AIDS was generally low among the children. Orphans were more likely to have heard about HIV epidemic and more likely to have positive attitudes toward PLWHAs than non-orphans. Among the orphans, single orphans were more likely to have

heard of HIV and AIDS but, double orphans were more likely to have positive attitudes towards PLWHAs. Knowledge of modes of HIV transmission and prevention was higher among orphans than non-orphans and higher among paternal orphans than maternal orphans.

The data on sexual activity among the children showed that 21% of the children aged 13 – 17 years had romantic boy/girl friends while 16% of the children of this age group reported that they had ever had sexual intercourse. Children in rural communities were more sexually active than children in urban and semi-urban communities while more girls were sexually active than boys. The data further showed that urban and semi-urban children were more likely to engage in risky sexual behaviours than rural children. The orphans were more likely to have engaged in sexual activity and less likely to have adequate knowledge of sexual and reproductive issues than non-orphans.

The study recommended, among other things, support of traditional safety net of the extended family structure, including economic strengthening interventions for OVC households. Additionally, universal access to education and health care services is a fundamental necessity to alleviate the basic livelihood concerns affecting OVC identified in the study. Also, promotion of good health seeking and sexual behavior among children and their caregivers should be a high priority in at-risk communities.

SECTION ONE: INTRODUCTION

1.1 Background

In the past two decades, AIDS, wars and conflicts, malaria, hypertension, road traffic accidents and other related causes of deaths have orphaned and made vulnerable millions of children in the world. In sub-Saharan Africa, AIDS is the leading cause of death among adults ages 15-59; and as one consequence, an estimated 12 million children ages 0-17 have lost one or both parents to AIDS (UNICEF, 2006). Subbarao, Mattimore and Plangemann (2001) reported that before AIDS became rampant in Africa, only approximately 2% of children were orphans. The proportion has now reached 15 to17% in some countries. The number of AIDS orphans which was estimated at 12 million in 2000, now projected to increase to 35 million by 2010. The number of children orphaned from all causes in sub-Saharan Africa is expanding and reached 48.3 million at the end of 2005 (UNICEF, 2006).

Nigeria has one of the largest populations of orphans in the world. Out of the estimated 52 million children in 2001, about 5.4 million (10.3%) of the Nigerian children were orphans, and 995,000 (18.4% of the orphans) were orphaned due to AIDS, making Nigeria, as of 2001, the country with the probable highest number of AIDS orphans in the world. In 2003 alone, 800,000 children orphaned by AIDS were added to the estimated 7 million orphans in Nigeria (FMWA/UNICEF, 2004). By 2010, 8.2 million children are projected to be orphans from all causes. UNAIDS (2006) reported that 1.3 million children lost one or both parents to AIDS in Nigeria in 2005. Other causes of orphaning in Nigeria have been identified to include maternal mortality, sectarian and ethnic conflict while large numbers of children are made vulnerable due to poverty, conflict and gender inequality.

There are wide variations across regions and communities in the prevalence and burden of orphans and other children (OVC). Studies in various African countries have demonstrated that OVC are unevenly distributed across communities (Nyangara, 2004)[1]. In countries with time-series household surveys, a trend emerged indicating that the burden of orphan dependency on working adult members of the family had increased disproportionately in rural areas while remaining constant or declining in urban area. This suggests a shift of the economic and social burdens from urban to rural thereby increasing the child's vulnerability in the latter. The surveys also revealed that in sub- Saharan Africa, non-relative child fostering (once an uncommon practice) has increased in some countries. The study further showed that the proportion of orphans who had lost both parents and were under the care of non-relatives increased in four countries – Kenya (3.1% to 8.7%) Tanzania 2.1% to 4.2%), Namibia (4.9% to 9.3%) and Zambia (2.2% to 3.5%). The results were an indication that the number of relatives that care for orphans has declined or that these relatives have become overburdened.

[1] *Based on existing Demographic and Health Survey (DHS) and Multiple Indicators Cluster Survey (MICS), Nyangara conducted an analysis of orphans and vulnerable children in 13 countries in sub-Saharan Africa and the Caribbean to examine the situation of orphans in these countries. The results showed that in each country, there were sub-regions that had orphan rates substantially higher than the national average, which was an indication that the orphan burden was disproportionately distributed among communities. For example, the national orphan prevalence rate in Ethiopia was 10.7% but much higher rates were found in Addis Ababa (15.7%), Affar (20.7%), and Somali (14.4%) sub- regions.*

Evidence also exists to show that orphans are more vulnerable than non-orphans. Recent studies have indicated that educational outcomes and nutritional status of orphans are worsening. A cross-country data assembled by UNICEF showed that children who are double-orphans are less likely to be in school than non-orphans. Ainsworth, Beegle and Koda (2000) also found that in Tanzania, maternal orphans and children in households with recent adult deaths delayed primary school enrolment. The study further revealed that the loss of either parent or the death of other bread-winning adults in the family setting produced a negative effect on the growth of such children and sometimes resulted in stunted growth.

Orphanhood and the problems it poses for countries and communities required a combination of national and targeted interventions. In many countries, public responses to orphan crisis have been very slow. However, in some countries, governments have enhanced social protection programs for orphans.[2] In Nigeria, there has been a history of efforts by the government, UNICEF, Save the Children (UK) and other agencies to address the needs of children particularly those in need of special protection on account of being in vulnerable conditions. Unfortunately, many children continue to be deprived of the full enjoyment or access to their fundamental rights in Nigeria. Factors in contemporary Nigeria such as inadequate public social services, high rate of poverty in the population, incidences of harmful traditional practices (HTP), gender inequities, coupled with inadequate policies, (though these are in the process of being developed), have made many children vulnerable to the denial and abuse of their rights despite meaningful efforts which have been put in place to ensure the achievement of the rights of children.

According to the National Plan of Action on Orphans and Vulnerable Children in Nigeria, an orphan 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 orphans". Vulnerable children are more difficult to categorize. The definition of vulnerability varies from society to society and is community specific. In consultation with stakeholders including children, the National Action Plan on OVC enumerated the list of children perceived as extremely vulnerable in Nigerian communities. While not exhaustive, it focuses on groups of children who are less likely to live a normal life in comparison to their peers.

[2] *For example, the Zimbabwean government is currently coordinating the efforts of multiple actors and has also planned special interventions for orphans with the help of the World Bank and other donors. In Eritrea, the World Bank is supporting large-scale efforts to assist orphans through Eritrean Integrated Early Childhood Development Project. Also, the Zambia Investment Fund recently developed a programme for children in difficult situations (the National Orphan Programmes). The programme was established in 1999 and is managed in partnership with government departments and Non Governmental Organizations (NGOs) working with orphans, especially in Uganda and Burundi, where they have played a leading role in addressing the plight of orphans.*

Vulnerability Factors

Vulnerability is indicated in children:

- from poverty stricken homes
- with inadequate access to educational, health and other social support
- abandoned to their fate and are having to fend for themselves
- under bondage, which compels them to carry out certain duties and responsibilities that mortgage their childhood by implication
- engaged directly or indirectly in works of any form that are abusive of their rights and exploitative of their status as children
- in homes/families where moral decadence indiscipline and indecency are tolerated or overlooked
- which have chronically ill parents (regardless of whether the parents live in the same household as the child)
- who live in a household with terminally or chronically ill parent(s) or caregiver(s)
- who live with old/ frail grandparent(s) or caregiver(s)
- who live outside of family care, i.e. live with extended family, in an institution or on the streets
- who are infected with HIV

Source: National Plan of Action (NPA), 2006-2010

List of Extremely Vulnerable Children

~ Children with physical or mental disabilities
~ Sexually abused children
~ Neglected children
~ Children in conflict with the law
~ Exploited "Almajiri"
~ Child beggars, destitute children and scavengers
~ Children from broken homes
~ Child labourers, including domestic child workers
~ Children in child-headed homes
~ Internally displaced children
~ Children hawkers
~ Trafficked children
~ Children of migrant workers such as fishermen and nomad
~ Children living with HIV
~ Children living with aged/frail grandparents
~ Child sex workers
~ Children whose parents have disability
~ Children who marry before age 18
~ Children who have dropped out of school
~ Abandoned children
~ Children living with terminally or chronically ill parent(s) or caregiver(s)

Source: National Plan of Action (NPA) 2006-2010

1.2 The Problem

Although the plight of the OVC is acknowledge throughout Nigeria, it has not received adequate attention from researchers, social workers and human rights workers. Lack of empirical data on the conditions of OVC has hampered the development of effective policies and programs to address the specific needs of OVC in Nigeria. The insufficient knowledge and clarity regarding the magnitude of the problem, including possible interventions, the strength (or weaknesses) of existing coping strategies, and capacity and resources for implementation of interventions, impact the quality of responses that is needed to adequately address the severity of the crisis. As a result, the National Plan of Action on OVC in Nigeria strongly recommended that a situation analysis of OVC be conducted urgently.

Catholic Relief Services (CRS)/Nigeria program, in partnership with the Catholic Secretariat of Nigeria (CSN) and 10 Catholic dioceses in eight states across the North-Central and South-South geo-political zones of Nigeria recently received financial support from USAID/Nigeria to implement the "SUN" (*Scaling Up the Nigerian Faith-Based Response to HIV & AIDS in Nigeria)* project. This is a three year initiative designed to improve the

quality of life of orphans and children made vulnerable by HIV & AIDS in Nigeria. The SUN project is being implemented in the 10 Catholic Dioceses of Makurdi, Otukpo, Lafia, Kaduna, Kafanchan, Jos, Minna, Idah, Benin and Abuja (covering Benue, Kaduna, Plateau, Niger, Kogi, Nassarawa, Edo states and FCT).

1.3 Purpose of the Survey

Due to lack of information on the OVC situation in Nigeria and the urgent need to have reliable data on prevalence, pattern, conditions and severity of OVC in the country as well as to provide benchmarks for SUN/OVC project, the Catholic Relief Services (CRS)/Nigeria conducted a situation analysis of OVC in eight states in Nigeria. The study was conducted in collaboration with the United States Agency for International Development (USAID), the Federal Ministry of Women Affairs (FMWA), the Catholic Secretariat of Nigeria (CSN), the National Action Committee on AIDS (NACA) and as well as other national stakeholders and implementing partners. The findings of the study are expected to serve the dual purposes of providing benchmarks for monitoring and evaluation of the CRS-OVC project and making available a detailed analysis of OVC situation in Nigeria for the use of other stakeholders.

1.4 Aims and Objectives of the Survey

The primary aim of this survey was to understand the current situation of orphaned children in the selected states and to assess current models of care in order to strengthen and improve strategies that aim at addressing the orphan-related needs of individuals, households, and communities.

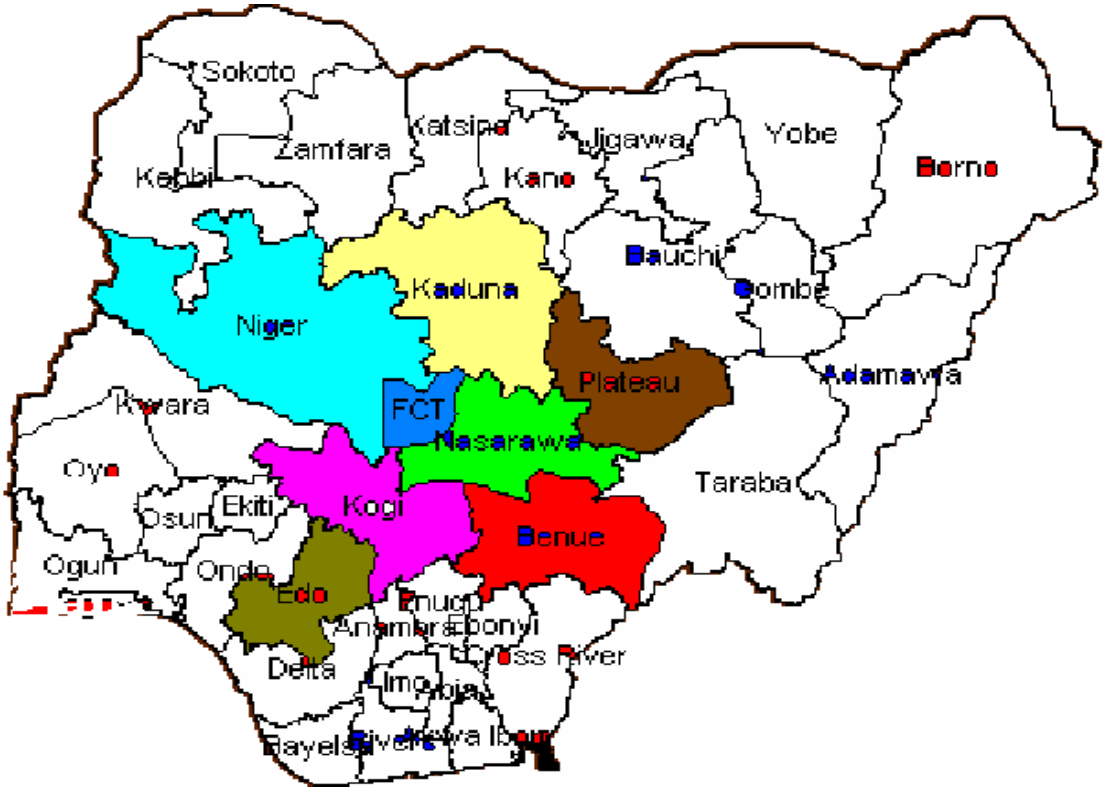
Specifically, the study had the following objectives:

- To provide detailed information on prevalence, patterns, conditions, severity and vulnerability factors of OVC in the 10 project dioceses (OVC status)
- To identify the extent of the needs of OVC compared to that which is being currently provided (GAP Analysis)
- To assess the conditions of OVC in comparison with other children in order to determine the extent and peculiarity of their vulnerability
- To determine OVC and Caregivers perspectives on OVC and HIV & AIDS related issues

SECTION TWO: METHODOLOGY

2.1 The Population

The situation analysis covers 8 states in Nigeria including Benue, Kaduna, Plateau, Niger, Kogi, Nasarawa, Edo States and the Federal Capital Territory (FCT). The population of the study comprised of children below age 18, their caregivers and community and religious leaders in the study states



2.2 Sampling Procedure

The study used a multi-stage stratified probability sampling method to select primary sampling units (PSU). The method followed the steps below:

Step 1: Stratification of the list of all local government areas (LGAs). This was carried out for all the states for the study. All the LGAs in each of the states were stratified into rural, semi-urban and urban.

Step 2: Random selection of one rural LGA, one semi-urban and one Urban LGA. This was done by making a random pick of a LGA from a list of LGAs in each stratum.

Step 3: Selection of one community in each LGA. The communities in each LGA were arranged and numbered in alphabetical order after which the random number table was used to choose a random number between one and the number of communities listed to identify the selected community. The communities selected were of mixed economic strata of the society.

Step 4: Transect walk (or a quick drive through the communities) and preparation of a sketch map of the selected communities, this was done to identify the names of roads, lanes and street. Some of the local persons helped in the drawing of a proper map of the selected communities.

Step 5: Division of the Selected Communities into Segments: Based on the sketch map, the selected communities were divided into segments (four or more segments) with approximately the same number of dwellings/houses from which two segments were selected randomly. The size of the segments in terms of geographic area varied considerably; densely populated areas were having geographically small segments and low-density segments were larger.

Step 6: Selection of households in the Selected Segments. After identifying a starting point, every fifth house/dwelling was selected and interviews were conducted with eligible respondents in the household. In situations where there were more than one household in the dwelling, selection of a household with at least a child below age 18 was done randomly and the next dwelling/household was chosen in case of non eligibility or decline to participate.

Step 7: Selection of Eligible Respondents in the Household: Eligible respondents were one orphan and one non-orphan aged 6-17 years randomly selected among the children in households where both existed. In households where only non-orphans or orphans existed, a respondent was selected randomly among the children. The caregiver of the children, mostly mother, in each selected household was selected as respondent.

Efforts were made to conduct interviews with the eligible respondents in the selected households. In many instances, repeated visits were made before getting the selected household members to be interviewed

2.3 The Samples

The participants/respondents for the Focus Group Discussions (FGDs) and Key Informant Interview (KII) were drawn from the communities where quantitative surveys were conducted.

Focus Group Discussions

In each state, at least 3 FGDs and 1 FGD were held with children and caregivers respectively. In all, 27 FGDs were held in the 8 states as shown below:

- 8 Focus Group Discussions with children 9-12 year-old groups (Males & Females)
- 8 Focus Group Discussions with children 13-17 year-old groups (Males & Females)
- 8 Focus Group Discussions with caregivers (Males & Females)
- 1 Focus Group Discussions with Almajiri children aged 6-17years (Males only)
- 1 Focus Group Discussion with street children aged 13-17 years (Males and Females)
- 1 Focus Group Discussion with street children aged 13-17 years (Males only)

The participants in the FGD (children group) were purposively selected using the following criteria:

Children aged 9 to17 years that were:

- Orphans (single and double)

- Children living with people other than their parents
- Children with disabilities
- Street children
- Almajiris

Participants in the caregivers' FGD were persons aged 18 and above, who were:

- Taking care of children other than their biological children
- Taking care of children with disabilities
- Widow or widower who was taking care of biological children

Key Informant Interview

Community leaders, religious leaders (Christians and Muslims) and service providers were identified and interviewed from each of the communities to provide generic information about the conditions of orphans and vulnerable children in their respective communities. The breakdown of those interviewed is shown below:

- 19 Community Leaders
- 5 Religious Leaders
- 6 Service Providers

2.4 Sample Size

A total of 2580 caregivers and 3086 children aged 6-17 years were systematically selected as respondents for structured questionnaires (quantitative) while 27 focus group discussions were held with four (4) distinct groups, including OVC children aged 9-12, OVC children aged 13-17, street children aged 9-17, and OVC caregivers. Thirty-one key informant interviews were also held with community leaders, religious leaders and OVC related service providers.

2.5 Data Collection Instruments

Eight data collection instruments were developed, validated and used for the collection of both quantitative and qualitative data from the children, caregivers and other key informants in the communities. The instruments were:

1. Structured Questionnaire for children aged 6-17 years
2. Structured Questionnaire for caregivers
3. Semi-Structured Focus Group Discussion Guide for children aged 9-12 years
4. Semi-Structured Focus Group Discussion Guide for children aged 13-17 years
5. Semi-Structured Focus Group Discussion Guide for caregivers
6. Semi-Structured Focus Group Discussion Guide for street children.
7. Semi-Structured Key Informant Interview Guide for Community and Religious Leaders
8. Semi-Structured Key Informant Interview Guide for Service Providers

The instruments were pre-tested at communities other than those used for the survey at Benue and Osun States, to establish their validity and reliability. The pre-testing data were collated, coded, entered, cleaned and analyzed using Statistical Package of Social Science (SPSS 14). In assessing the reliability and inter item cohesion for the questionnaires, Cronbach Alpha coefficient of .75 was established for the children's questionnaire and .76 for caregivers' questionnaire, indicating 75% and 76% reliability for children and caregivers questionnaires

respectively. Peer review researchers and professionals in the field of OVC were used to establish face validity for the instruments and appropriate corrections were effected.

2.6 Training of Field Officers

Two levels of trainings were conducted. A training of trainers (TOT) was conducted centrally for the core research team (team leaders and supervisors) comprised of the consultants, CRS program managers, partners' staff and staff of other agencies. The training focused on the rationale and the objectives of the study, the sampling procedure, survey/interview techniques, ethical issues, overview of the contents of the draft instruments, training/facilitation guides and allocation of roles and responsibilities. The TOT lasted for three days.

The second level of training was conducted in each state. The field officers (interviewers) were specially trained for the survey during the three-day training. The training focused on data collection procedures, interview techniques and interpersonal skills with special focus on OVC and HIV & AIDS related issues. During the training, the team leaders (facilitators) reviewed each question in the questionnaires to ensure that the interviewers were familiar with them. Each question was translated verbally into local languages and then translated back to English to ensure appropriate translations. Special attention was given to translation of key concepts. The trainings were highly participatory involving role-plays, demonstrations and critiques in small groups and plenary sessions. The field officers were all given opportunities to be observers, and participants in role-plays (as interviewer or respondent) at various points during the trainings. At the end of the training, skills of the interviewers were verified by the facilitators to be adequate through role-play and return demonstration.

2.7 Data Collection Procedure

The interviewers conducted face-to-face interviews with the respondents (children and caregivers).[3] The interviews were conducted in English or the local language widely spoken in each study area depending on the preference of the person interviewed. In order to avoid gender bias in responses and respect cultural restrictions, interviewers were paired (male and female) to interview respondent of the same sex. Privacy was ensured by conducting the interviews in open but separate environments free from distractions. Verbal consent was received from each respondent and also from parent or the guardians of all children by explaining the purpose of the study that participation in it was voluntary, and that information provided would be kept confidential.

The FGDs and KII were facilitated by the team leaders with the assistance of interpreters, when necessary. All FGD and KII sessions were tape recorded to ensure the effective coverage of the interview and for reference purpose. Case studies were taken from identified people in the community to explain and reflect upon the situation of orphans and vulnerable children.

[3] *Face-to-face interview was preferred to self administered method because field experiences with surveys of young people in Nigeria showed that the former usually yield better rate of response and produce more reliable data than the latter.*

2.8 Non-Response Rate

Generally, the non-response rate was very low (less than 5%). However, the non-response rate was high in a low density, high-class urban setting of Abuja (Asokoro) where a 70% non-response rate was recorded. The non-response across all sites was 134 out of the total of 5800 questionnaires administered, indicates 2 % non-response rate.

2.9 Data analysis

Completed questionnaires were collated and entered into the computer. The data was analyzed with the Statistical Package for Social Sciences (SPSS) computer software and the results were presented in simple percentages. Analysis was stratified by state, type of vulnerability, residence and sometimes by sex to show differences in variables of interests. Descriptive statistics were used to profile the study population.

2.10 Limitations

The survey was carried out within the following limitations:

1. Children under age six were not interviewed. Some important information about infants and pre-school children might have been excluded in the report. Additional research will need to be administered to capture this information.

2. The survey was conducted in 8 (including FCT) out of 36 states in Nigeria. Findings in this report should therefore be used with caution in respect of generalizing for the country.

3. Due to language differences and logistics difficulties, team composition varied from site to site. Each site had a different set of people administering the questionnaires; however key team members remained constant and training and methodology was standardized.

SECTION THREE: DEMOGRAPHIC CHARACTERISTICS

3.1 Characteristics of all Children in the Households

A census of all children in the 2580 households sampled showed that a total of 10211 children were living in the households, implying an average of 4 children per household. The average number of children per household ranged from 3.2 in Kogi to 4.6 in Niger state. More than a half (53%) were males while 47% were females. In all states with the exception of Benue State, there were more boys than girls.

Table 1: Socio-Demographic Characteristics of all Children in the Households

Household/Children Characteristics	FCT	Benue	Nassar	Niger	Kad	Plateau	Kogi	Edo	Total
No of household surveyed	108	349	226	351	681	295	280	290	2580
No of children in the HH	417	1313	831	1605	3052	1063	899	1031	10211
Sex: % Male	54	50	53	57	53	52	51	52	53
% Female	46	50	47	43	47	48	49	48	47
Average children per HH	3.9	3.8	3.7	4.6	4.5	3.6	3.2	3.6	4.0
% of single orphans	12	28	24	21	18	25	32	22	23
% of double orphans	02	12	08	06	03	06	04	03	05
% of children who are orphans	14	40	32	27	21	31	36	25	28
% of children currently schooling	69	73	82	73	80	75	88	82	78

Out of the 10211 children in the households, 2824 (28%) of them were reported to have lost one or both parents while the remaining 72% had both parents alive. Benue State had the highest percentage of orphans (40%), followed by Kogi state (36%) while FCT had the lowest percentage of orphans with 14%. When disaggregated into single and double orphans, 23% of the children were single orphans and 5% were double orphans. Kogi state recorded the highest percentage of single orphans (32%) while Benue state had the highest percentage of double orphans (12%). Educational status of the children showed that 78% of the children in the households were currently attending school. FCT recorded the lowest enrolment rate (69%) while Kogi state had the highest (88%).

3.2 Household Facilities

In the Caregivers questionnaire, respondents were asked about certain characteristics of their households, including sources of drinking water, type of toilet facilities, and type of refuse disposal system, main source of energy for cooking and for lightning. The characteristics of the household are useful indicators of the socioeconomic status of the household which also have important bearing on children exposure to disease.

The data in table 2 shows that basic household and sanitary facilities in most of the sampled households were inadequate. For example, majority of households lacked access to safe drinking water as only 15% and 13% had access to piped water and borehole, respectively. More than one-third (36%) of the households depended on Dug Well for drinking water. 15% of the households relied on water bought from vendors for drinking while 19% normally fetched drinking water from rivers/streams. Niger State recorded the highest proportion of households with access to piped water (34%) while households in Edo state had the lowest (2%) access to piped water. Bore-hole (58%) was the major source of drinking water for the

sampled households in Edo state. More than a half (54%) of the households in Kogi State usually bought their drinking water from vendors.

Table 2: Households' Access to Water and Sanitary Facilities

Household/Sanitary Facilities	FCT N=103 (%)	Benue N=349 (%)	Nass N=226 (%)	Nig N=351 (%)	Kad N=681 (%)	Plat N=295 (%)	Kogi N=280 (%)	Edo N=290 (%)	Total 2580 (%)
Main Source of Drinking Water:									
Pipe in Dwelling	08	18	10	34	13	21	06	02	15
Borehole	33	03	14	05	09	04	04	58	13
Dug Well	03	20	31	55	54	59	04	16	36
Tanker/Vendor	09	50	15	0	02	02	54	05	15
River/Stream	45	05	30	06	23	13	30	18	19
Others	01	05	0	0	0	0	03	01	01
Type of Toilet:									
Flush/Water system	12	38	09	09	08	14	12	35	17
Pit latrine	41	24	72	79	66	70	71	50	61
Bush	47	38	20	11	26	16	16	15	22
Type of Refuse Disposal System:									
Bin Collected by agents									
Disposal Pit	05	14	05	01	05	03	06	17	07
Refuse Dump	39	13	28	15	41	12	38	52	30
Others	50	70	66	84	53	84	51	26	61
	03	02	01	0	01	01	05	03	02

Similarly, only 17% of the households had access to hygienic toilet facility (flush/water system). Close to two-third (61%) of the households were using pit latrine while 22% used nearby bushes as toilets. Disposal of waste by households in all study states was primarily at refuse dumps (61%) while 30% of the households usually disposed their refuse in disposal pits at a safe distance for sanitary reason. Bin collectors were the least used option for disposing waste (7%). Ironically, households in FCT had one of the worst access to basic household –and sanitary facilities. This can be explained by the fact that the selected communities in FCT were predominately from the lower socio-economic strata. The FCT has a high level of disparities with infrastructure and resources being heavily concentrated within the Abuja Municipal Council.

Table 3: Main Sources of Energy for the Households

Source of energy	FCT N=103 (%)	Benue N=349 (%)	Nass N=226 (%)	Niger N=351 (%)	Kad N=681 (%)	Plat N=295 (%)	Kogi N=280 (%)	Edo N=290 (%)	Total N=2580 (%)
Main Source of cooking energy									
Electric/Gas	03	01	01	02	01	02	01	02	02
Kerosene	10	14	05	04	15	12	11	40	14
Firewood	85	77	92	92	82	80	84	58	81
Charcoal/Saw dust	02	09	03	02	01	07	04	01	04
Main source of energy for lighting:									
Electricity	24	43	14	54	41	32	39	56	40
Candle	01	01	0	01	01	02	0	02	01
Kerosene	72	55	81	43	58	59	59	41	56
lantern	0	0	05	01	0	02	01	01	01
Gas/Rechargeable lamp	03	01	0	01	0	05	01	0	02

Access to efficient source of energy was also very poor among the sampled households. The majority of the households used firewood as the main source of energy for cooking (81%). Only 2% and 14% of the households used electric/gas and kerosene (respectively) to cook. Only two in five (40%) of the households reported electricity as their main source of lighting

while more than a half (56%) used kerosene lantern most of the time for lighting. Households in Edo (56%) and Niger (54%) had the best access to regular supply of electricity while households in Nassarawa had the least access to electricity

3.3 Characteristics of the Respondents (Children)

The study was based on a sample of 3086 children drawn from the 2580 selected households in the 8 study states. The largest sample size was drawn from Kaduna state (21%) while the least number of respondents were from the FCT (5%). The mean age of the respondents at last birthday was 12 years. More than half (53%) of the respondents were between ages 6-12 years while 47% were aged 13 to 17 years. Fifty-one percent of the samples were males while 49 per cent were females.

Table 4: Socio-Demographic Characteristics of the Respondents (Children)

Demographic Characteristics	FCT N= 162 (%)	Benue N=437 (%)	Nassar N=279 (%)	Niger N=530 (%)	Kaduna N=674 (%)	Plateau N=337 (%)	Kogi N=322 (%)	Edo N=345 (%)	Total N=3086 (%)
Sample Size	05	14	09	17	22	11	10	11	100
Sex:									
Male	48	44	49	62	52	48	45	50	51
Female	52	56	51	38	48	52	55	50	49
Mean Age									12
With Disability	03	03	05	05	11	15	03	08	07

About 7% of the children interviewed were living with disabilities. Plateau (15%) and Kaduna (11%) states recorded the highest percentages of children living with disabilities. The types of disability reported by the children included: speech impairment (1.9%), physical disability (1.3%), sight impairment (1.2%), learning disability (0.6%), hearing & speech impairments (0.5%) and others (1.5%).

3.4 Characteristics of Respondents (Caregivers)

A total of 2580 caregivers who were mothers, fathers or guardians of the children respondents were also interviewed. Majority of the caregivers (68%) were females while 32% were males. Majority of the caregivers (82%) were married, 11% were widowed, while singles accounted for 3%. One-quarter of the caregivers were farmers while 18% were civil servants and business women/men respectively. Other occupations of the caregivers include: traders (15%), housewives (14%), artisans (2%).

Table 5: Characteristics of the Respondents (Caregivers)

Demographic Characteristics	FCT N=103 (%)	Benue N=349 (%)	Nass N=226 (%)	Niger N=351 (%)	Kad N=681 (%)	Plat N=295 (%)	Kogi N=280 (%)	Edo N=290 (%)	Total N=2580 (%)
Sex: Male	8	23	44	71	16	16	48	30	32
Female	92	77	56	29	84	84	52	70	68
Marital status:									
Single	03	06	05	06	02	02	01	01	03
Married	05	78	87	81	84	86	82	73	82
Separated	0	0	01	02	0	01	01	04	01
Divorce	0	01	0	01	0	02	03	02	01
Widowed	03	15	07	09	13	01	13	19	11
Occupation:									
Civil servant	10	17	19	28	13	11	31	16	18
Farmer	12	36	32	31	29	25	10	25	27
Trader	26	07	12	12	09	14	24	33	15
Artisan	0	01	0	0	01	02	03	01	02
Business	0	21	17	11	16	29	25	10	18
Housewife	13	08	12	08	25	15	03	08	14
Caregiver	33	02	0	0	03	01	0	01	01
Others	0	07	05	03	05	03	04	05	05

3.5 Discussions

Kaduna state had the largest sample size because of its large population and the fact that the state has two Catholic dioceses (Kaduna and Kafanchan). The religious affiliation of the respondents showed the fact that the respondents were selected randomly without religious bias. It is also worth noting that the sample cut across over 25 ethnic groups/tribes, none of which was large enough to be reported as majority. This reflects the ethnic and cultural diversity of the country, which should be considered in programming.

The household data revealed a high average number of children per household. Hence, any household based intervention for orphans (e.g nutrition supplement/food supplies) should recognize this fact and include other children in the household in the planning. This is to ensure that both the intended target (orphans) and other children in the household benefit from the program to avoid discriminations against the orphans within the household, which may make them more vulnerable.

The findings showed that more than a quarter (28%) of the children in the study states were orphans. It is therefore estimated that there are 4.2 million orphans[4] in the study area. The high percentage of the orphans in the study areas (compared to the national average) may be as a result of high HIV prevalence in the area (north central region has the highest HIV prevalence in Nigeria). It may also suggest an astronomic increase in the prevalence of orphans in the country. UNICEF (2006) reported that the number of orphans from all causes has risen by more than 50% in sub-Saharan Africa largely due to loss of one or both parents to AIDS.

[4] Based on the NDHS 2003 estimate that 55% of the Nigerian population is under 18 years, and using 2006 population census, the estimated population of children in the study areas as the time of the survey was 15 million.

SECTION FOUR: ORPHANS AND VULNERABLE CHILDREN

4.1 Magnitude of Orphans and Other Vulnerable Children

Six categories of orphans and vulnerable children (OVC) were identified in the study to include:

- Children that have lost one parent (Single orphans)
- Children that have lost the two parents (Double orphans)
- Children whose parent(s) is/are chronically ill
- Children living in households where a chronically ill adult died recently
- Children living with old frail grand parents or guardians
- Children with disabilities

Table 6: Percentage of Orphans and Vulnerable Children by States

State	Double Orphan N=249 (%)	Paternal Orphans N=566 (%)	Maternal Orphan N=175 (%)	**Total Orphan N=990 (%)**	Parent ill N=102 (%)	Dead Adult N=38 (%)	Frail Guardian N=25 (%)	With Disability N=210 (%)
FCT	02	11	03	**16**	02	-	-	03
Benue	16	20	06	**42**	03	01	01	03
Nassarawa	07	23	07	**37**	05	02	03	05
Niger	06	15	03	**24**	04	01	01	05
Kaduna	04	16	07	**27**	06	02	-	11
Plateau	18	18	06	**42**	02	01	02	15
Kogi	06	25	08	**39**	02	01	01	03
Edo	03	21	04	**28**	01	01	03	07
TOTAL	08	18	06	**32**	04	01	01	07

About 45% of the children interviewed were vulnerable by at least one of the above-mentioned conditions. About one-third (32%) of the children interviewed were orphans (8% double and 24% single), 7% were living with disabilities, parents of 4% of the children were chronically ill and 1% of the children were living in households where a chronically ill adult died recently and with old frail grand parents/guardians. However, it is important to note that orphans were preferentially chosen for interviews to have statistically significant number of orphans in the sample. A child may also be affected by more than one condition. For example, 56% of children living with old frail grand parents/guardians and 43% of the children living with disability were orphans.

The percentage of OVC interviewed varied across the states. Benue and Plateau States had the highest response rate of orphans (42% each), followed by Kogi (39%) and Nassarawa (37%) while FCT has the lowest rate (16%). When disaggregated to double and single orphans, Plateau state had the highest rate of response for double orphans (18%), followed closely by Benue state (16%) while Kogi has the highest rate of single orphans (33%). Plateau State had the highest (15%) percentage of children with disabilities among the children interviewed while Kaduna state had the second highest (11%). The proportion of children whose parents were chronically ill and children who were living in households

where a chronically ill adult died recently were generally low (ranged between 1% in Edo and 6% in Kaduna).

Table 7: Percentage of Orphans and Vulnerable Children by Residence, Sex and Age

	Residence				Sex			Age		
Issues	Urban (%)	Semi urban (%)	Rural (%)	X^2	Male (%)	Female (%)	X^2	6-12 (%)	13-17 (%)	X^2
Non orphan	71	67	65	.014	68	68	.381	69	66	.055
Orphan	29	33	35		32	32		31	34	
Double	05	10	09	.000	07	09	.268	08	08	.161
Single:	24	23	27		24	23		23	26	
Paternal	19	17	19	.000	19	17	.074	18	19	.092
Maternal	05	05	08		05	06		05	07	
Living with disability	06	07	08	.125	07	07	.525	07	06	.234
Living with chronically ill parents	03	01	07	.000	03	03	.751	03	04	.058
Living with old frail guardian	01	01	01	.000	01	01	.654	01	01	.450
Living in HH where an adult died recently	01	01	03	.000	01	02	.496	01	02	.616

The data in table 7 above shows that rural area had a higher proportion of orphans (35%) than semi-urban (33%) and urban (29%) areas. Rural area also had highest percentages of single orphans and maternal orphans. However, the proportion of double orphans was slightly higher in semi-urban than rural (10% vs 9%) while, rural and urban areas had the same percentage of paternal orphans (19%). Similarly, rural area had the highest percentages of children living with disability (8%), children living with chronically ill parents (7%) and children living in households where a chronically ill adult died recently (3%).

There were no significant gender differences in the proportion of orphans and vulnerable children. For example, equal proportion (32%) of the males and females were orphans, living with disability, living with chronically ill parents and living with old frail grand parents/guardians. However, more females (9%) had lost both parents than males (7%) while more males have lost their fathers than females (19% vs 17%).

The qualitative data revealed that communities had different local names for orphans. The names and their meanings are presented below as mentioned by children, caregivers and community leaders:

Table 8: Names of Orphans as mentioned by Respondents

Children	Caregivers	Community leaders
Omayokor (Igala)- A child without either father or mother or both **Maraya** (Hausa) – A male child without either father or mother or both **Mariniya** (Hausa)- A female child without either father or mother or both **Oyokwo** (Idoma)- A child without a mother or both of them are dead **Oyokwo-ada** (Idoma)- A	**Omayokor** (Igala)- A child without either father or mother or both **Maraya** (Hausa) – A male child without either father or mother or both **Mariniya** (Hausa)- A female child without either father or mother or both **Oyokwo** (Idoma)- A child without a mother or both of them are dead **Oyokwo-ada** (Idoma)- A child without a mother **Anchoov, Anchough** (Tiv)- A child without any support **Umerah** (Esan) – This is a child without a father **Kwi** (Gwari)- A child that has lost one/both parents	**Anchoogh** (Tiv): one who has lost one or both parents **Maraya** (Hausa): a male that does not have parent(s) **Marania** (Hausa): a female who has lost one or both parents **Akwi** (Gbagi): one who has lost one or both parents **Banyuke** (Koro): one who has lost one or two parents **Mai Danyo Me Mai** (Fulani): one who has lost

child without a mother **Anchoov, Anchough** (Tiv)- A child without either father or mother or both **Umerah (Esan)** – This is a child without a mother **Kwi (Gbagyi)** - A child that has lost one/both parents **Oyoku (Ebira)** - A child that has lost one/both parents	**Oyoku** (Ebira)- A child that has lost one/both parents **Akunyi** (Gbagyi)- A child that has lost one/both parents **Wenafu** (Jaba)- A child that has lost one/both parents **Omoimi** (Edo)- A child that has lost one/both parents **Omoorukan** (Yoruba)- A child with a troubled mind **Omoarore** (Bini)- A child that has lost one/both parents **Nwa ne nwegi nne na nna** (Igbo)- A child that has lost the father or mother or both **Omoalainiya** (Yoruba)- A child that does not have a mother **Omoalainibaba** (Yoruba)- A child that does not have a father. **Nyikee** (Koro)- A child that has lost both parents **Omoorukan** (Yoruba) – A child with troubled heart	one or two parents **Omainikan** (Esan, Edo): A child that does not have a father and/or mother. **Udefiagban** (Bini, Edo): A child that does not have a father and/or mother **Omorevbera** (Bini, Edo): A child that does not have a father and/or mother

Basically, there was no difference in the names given by the groups except that the caregivers gave more names. Some of the literary meanings of the names orphans are called reflect emotional feelings and community's perceptions of the plight of orphans. For example, **'Omoorukan'** (Yoruba) means 'a child with troubled heart'; **'Anchoogh'** (TIV) means 'a child without support'. These names could invoke sympathy and suggest the need for care and support for the orphans. Some tribes (e.g Hausa and Idoma) also had names depicting gender variation of orphans. In some cultures a child is not an orphan except the mother is dead. For example, the Esans in Edo State believe that if a child's mother is alive; he/she is not an orphan since the mother is the one caring for children. On the other hand, the Tivs in Benue state believe that if a child's mother is dead and the father is alive, he/she is not an orphan because the father provides the wherewithal to take care of the child and when he dies there is no means of livelihood for the family. They said that if the mother/wife died, the husband would marry another wife that would take care of the child.

Most of the children in the groups reported that there was an increase in the number of children loosing their parent(s). Some of the child participants mentioned malaria, HIV & AIDS, Typhoid, Cough, Gonorrhea, Epilepsy, Hypertension and accidents as causes of parents' death. Some other participants said more parents were dying because elders were no longer probing into the cause of death like they used to do in the past. However, some of the children did not know the reasons for the increase in death of parents in the community. FGD participants ages 6-12 years in a semi-urban community of FCT could not say exactly if more children were loosing their parents.

The general consensus at the caregivers' group discussions was that more parents are dying now than before. They gave enumerated causes of orphaning to include:

- Illnesses like, malaria, HIV & AIDS, hypertension, diabetes, typhoid, yellow fever, pneumonia, tuberculosis etc
- Accidents
- Poverty: having to care for many people with little resources
- Children killing their parents. A participant said, *"Children that are cult members even kill their parents now".*

Most of the community leaders said that there were many orphans in their communities. However, a disagreement was noticed in how much the community leaders knew about the state of orphans in their communities. For instance, in a rural community in FCT, a

community leader said there was no increase in number of orphans in the community while another key informant said that there was an increase in the number of orphans in the same community. A religious leader (who kept register of orphans) said there was an increase in the number of orphans in his church from 68 in 2004 to 154 in 2006. The church had a congregation of about 500 people. Many of the participants recognized the fact that the challenges faced by orphans are not unique or peculiar, as some non-orphan also experienced similar problems. Some community leaders said that other children suffered like orphans because of poverty, polygamy and conflict in their families.

4.2 Care and Support for OVC

The quantitative data showed that, on the average, each caregiver reported that they have 4 children that they cared for. At least one of the four (0.81) children under their care was an orphan, while one in every six (0.59) children in households was a non-orphan non-biological child[5]. The caregivers also reported that they spent an average of ₦5729 on health care for the children in the last 30 days preceding the survey. An average of ₦16224 was also reported to have been spent on children's education since the beginning of the current school term.

The discussions with caregivers, children and community leaders revealed the type and quality of care and support that were in place for the children within the communities. The participants in the children group (9-12years) reported that, in most communities the surviving parent usually cared for the single orphans while the double orphans were cared for by their grandparents and other extended family members. In some instances, orphans were the ones caring for their old frail grand parents. For instance a 10 year old girl assumed the role of a caregiver as she was responsible for taking care of her grandmother. She reported that she normally woke up before her grandmother, did her morning chores, and then woke her grandmother up before going to school. In other instances, the orphans were cared for by their religious leaders, who took them up when they lost both parents and had no one else to care for them. Such cases were reported by the participants in Plateau State.

Most of the participants in children groups reported that they wake up at around 6.00 a.m and perform some household chores which included; cleaning the house, taking care of their younger ones, cooking, and fetching water before going to school. Sometimes they ate before they went to school while at other times they ate at school. When they come back from school, most of them usually did some household chores and hawk or sell goods for their parents or guardian at home. A few of them reported that they had time to play or watch television and did their take-home assignments. Most of the children in the 13-17 year group said that they were not treated well in terms of care, education, emotional and social support. They said they were usually treated differently from the biological children of their guardians.

A girl in semi –urban community in FCT stated:

> *"They are maltreating us; they treat us differently from their children. They do not send us to school; they send us to farm, market and to hawk when their own children are in school. We actually do most of the household chores."*

According to a child in a semi-urban community in Edo state:

> "*We have to learn to survive on our own, extended family members do not care enough,"*

Another child in a rural community in Kogi states said:

> *"Nobody cares for us; people concentrate on their business and more on their children. Only your family takes care of you, and we have to work to care for ourselves"*

However, there were some positive comments from isolated cases. Some children said that they were well taken care of, they were sent to school, they had good clothes and they ate well especially during festive periods (Christmas & Sallah) when food items like rice & meat were given out to them.

Almost all participants in the caregivers' group reported that there were no structures in place at the community level to care for OVC. The surviving parent or the extended family members usually care for the orphans. They also reported that in some cases, families members may decide to put orphans in orphanages, especially when they were below age 5. In few other instances, some of the community members might take up the orphans to foster them.
The community leaders also agreed that the most common structures for care of orphans were those provided by the surviving parents, grandparents or extended family members. Some community leaders observed that the orphans were cared for by God. They also reported that at times the orphans lived on their own when there was no father, or mother or extended family member to take care of them. Some of the community and religious leaders acknowledged the fact that poverty among members of the community contributed to their inability to take up the responsibility of caring for orphans in their communities as they would have loved to do. One key informant in Kaduna state said:
"The way the orphans are brought up is not in a healthy manner. There is no sufficient food to feed them, if sickness occurs to the child, there is no drug to treat him because many Nigerians are underprivileged or poor. He (the poor Nigerian) doesn't have hospital, school or money"

4.3 Community and Organizational Support for OVC

The care and supports given to the OVC varied from communities. Majority of the participants in the children group complained that they were not being treated well by the community members and neighbors. Some of the children (especially girls that engaged in hawking) reported that they were often harassed physically and sexually by their customers. Some of the children said they were often accused wrongly of having bad behaviors. A boy in semi urban community in Kaduna state said:

> *"They insult us, we do not eat well, they send us on errands and they do not care about us".*

A boy in rural community in FCT said:

> *"Some people take my family as an evil family and people mock me"*

However, few of the children said they were well treated by the community members. For example, most of the children in Nasarawa state said that the community members took special care of them when compared with other children. The community also had structures in place to ensure that the orphans rights were protected, were properly cared for and basic needs were provided for them. It was noted that in some communities where the people followed the religious injunctions strictly, the orphans were better cared for.

Case Study 1: Adolescent Headed Household

Abu (not real name) is an 18year old boy living in Bida, Niger state. His parents were from Ebonyi state but he and his junior ones were born and raised in Bida. Abu's father died of HIV in 1998 and his mother was also tested positive of HIV in 2003 and later died of AIDS in 2005, leaving behind six children including Abu who was the eldest child.

After the death of his mother in 2005, Abu had to drop out of school to take full charge of the family business that his late father and mother used to manage together. He then assumed the role of a household head running the family business, paying all the bills for the household and ensuring that all his siblings stay in school. Abu has no extended family member to support him and his junior ones, except an aged maternal grandmother who lives in their village, in Ebonyi state .He is currently out of school and supports his siblings who are all in school. Abu is currently being mentored by a Community Based Organization (CBO) in Bida.

The participants in caregivers' groups reported that there were few organizations supporting OVC in the communities. Some of the organization mentioned include: religious groups from the Catholic Church like Parish Action Committee on AIDS (PACA), St Vincent de Paul, Catholic Women Organization (CWO), and other individuals from the church. Others include:

- Government orphanages
- A number of individual philanthropists
- Few Non Governmental Organizations like Yima Foundation in Apir, Makurdi, Child-to-child in Bida, Niger State, Ekundayo Motherless Home, Egbe, Kogi etc.

4.4 Effects of Taking-in Orphans on the Household

Most of the participants in caregivers group reported that there were both positive and negative effects of taking in orphans or additional children into their homes. The positive effects include:

- There were more people to do household chores, farming and community activities.
- More cordial relationship and closeness was fostered in the extended family

The negative effects included:

- Increased financial demands on education, health care, feeding, accommodation etc with the increased number of children in the household making living more difficult
- When preferential treatment is given to biological children, there is chaos in the household
- Taking on additional children compels the guardian to reduce standard of living for their own biological children. For instance, they might have to withdraw their own children from private schools to be able to maintain all the children in public schools.
- Spousal conflicts may increase as a result of the presence of the orphans in the household

Some of the caregivers complained that orphans were usually disobedient and troublesome in the homes, due to emotional problems that some of them faced as a result of the death of their parents. However, the caregivers were quick to add that this could be easily managed depending on the understanding and style used by the guardian in managing the situation. To buttress this point a widow in urban community in Kogi state who was also caring for other non-biological children said:

> *"In my own case, my foster daughter became very troublesome. When this problem came up, l took her to the church for deliverance. She has been going to church now voluntarily. She went through education successfully; she is now happily married and is grateful to me. It is important not to neglect them".*

Participants disagreed on whether male or female OVC was more difficult to manage. While some of the participants were of the opinion that girls (especially maternal orphans) were more difficult to manage. Others believed that the boys (especially paternal orphans) were more difficult to manage. However, they all agreed that mothers were able to manage girls better while fathers were in a better position to manage boys. Problems usually arise when either of them dies. Another female participant from a rural community in Edo had this to say:

> "*The female OVC are easier to care for than the males. They get married earlier and their husbands support the family while the male OVC are more difficult to care for because they need care and support for a longer time. When they eventually marry, they bring their wives home, which means there are more people to care for".*

In contrast, a widow in rural community of FCT argued that it was more difficult to take care of females. She said:

> *"It is more difficult and expensive to raise girls than boys because you have to buy make ups for girls, and dresses to prevent them from feeling inadequate among their peers. They also get more difficult as they attain puberty or when they start getting suitors and some of them might not obey their mothers/guardians."*

In order to cope or manage problems, most of the caregivers said they pray to God for interventions and help to come. They also tried to give the children religious and moral teachings from the churches or mosques in an effort to ensure their proper upbringing. Most of the widows in the group reported that they did not get support from anywhere after the death of their husbands. They had to struggle on their own to raise their children after they exhausted what their husbands left before their death. Most of the time, this resulted in adopting coping strategies which include:

- Join and borrow money from cooperative thrift and credit society
- When the resources were not enough to meet all household demands, they solved the immediate problem that was of highest priority.

Other guardians in the group said they got support from other members of the extended family when they could not cope with the demands of care needed by the orphans.

Some of the caregivers listed the problems they noticed in the children they have taken-in to include the following:

- The orphans usually felt unhappy when their needs could not be met especially when they saw other children as being better off than themselves
- Those whose academic needs were not met remained depressed especially when they were sent away from school.
- Conflicts among the children in the house was a source of emotional trauma, but this depended on how they were handled by the caregivers or guardians

The widows and grand mothers in the caregivers' group reported that they usually helped the children to cope with their emotional problems by persuading and talking with them.

Some caregivers, especially widows/widowers who were biological parents, said there was no circumstance that could make them abandon or reject their children who were orphans. Others caregivers said they could make alternative arrangements among other extended family members or reject the orphans if:

- She / he was very stubborn or is always getting involved in police cases,

- When a child had the habit of stealing, especially if the mother brought him/her from somewhere else.
- If they become prostitutes.

4.5 Discussions

The results indicate that the burden of orphans was higher in the rural areas. This might be due to the fact that mortality rate (especially, maternal) is higher in the rural areas because of inadequate access to modern health care facilities. It might also be as a result of the fact that orphans are usually sent back to their villages after the death of their parents in towns/cities because it is cheaper to care for them in the villages than in the cities.

It should be noted that majority of other identified vulnerable children (children living with old frail grand parents and those living in households where a chronically ill adult died recently and children whose parents are chronically ill) were also orphans. An intervention program targeting orphans would have included almost all categories of OVC identified in the study.

SECTION FIVE:EDUCATIONAL STATUS OF THE CHILDREN

Education is an important requirement for the development of a child. Schools can provide children with opportunities for emotional support, interaction with other children and the development of social network. Education can also reduce vulnerability to poverty and HIV through increasing knowledge, awareness, skills and opportunities.

5.1 Educational Status of the Children by State

The findings indicated that the majority of the children interviewed were currently in school.

Table 9: Educational Status of the Children by State

Educational Status	FCT N=162 (%)	Benue N=437 (%)	Nassar N=279 (%)	Niger N=530 (%)	Kad N=674 (%)	Plateau N=337 (%)	Kogi N=322 (%)	Edo N=345 (%)	Total N=3086 (%)
Currently in School	87	82	81	86	89	78	94	90	86
Not currently in School	13	18	19	14	11	22	6	10	14
Type of school being attended:									
Government	77	44	70	89	87	67	62	59	71
Private	13	26	28	8	10	24	20	36	19
Mission/Religious	9	29	1	1	2	6	6	4	7
Community	1	1	2	0.4	0.2	1	10	0.1	3
Ever missed school for one or More term(s)	12	12	15	10	13	10	09	15	12

About 86% of the children were currently attending school. Kogi state had the highest percentage of children in school (94%) while children in Plateau state had the lowest school enrolment rate (78%). It was also observed that more than 7 in 10 (71%) of the children who were currently in school were attending government owned school. Niger state had the highest percentage (89%) of children in government schools while Benue state had the least percentage (44%) of children in government schools. Less than a fifth (19%) were attending private schools, 7% were attending schools owned by religious organizations and 3% were attending community owned schools. In Benue state, more than a quarter (26% and 29%) of the children were attending private and mission schools, respectively. Twelve percent of the children reported that they had missed school for one or more terms due to problems ranging from lack of money to pay school fees to illness/death of parents. Children in Kaduna state reported the highest rate of absence in school for a period up to a whole term while Kogi state reported the least cases of absenteeism.

Of the 14% of the children of school age who were not currently attending school, 5% were never in school while 9 % once attended school but had to drop-out of school. Various reasons were given for drop-out from school including: lack of money to pay school fees, death of parents, disability, poverty and the need to work to support family.

5.2 Children's Access to Education by Residence, Sex and Age

The quantitative data showed that children in rural communities were more educationally disadvantaged compared to their counterparts in semi-urban and urban communities. Older children had less access to education than the younger children but, there was no significant difference between boys and girls in term of access to education.

Table 10: Access to Education by Residence, Sex and Age

	Residence				Sex			Age		
Issues	Urban (%)	Semi urban (%)	Rural (%)	X^2	Male (%)	Female (%)	X^2	6-12yrs (%)	13-17yrs (%)	X^2
Currently schooling	90	84	85		87	85	0.15	87	85	0.05*
Ever missed school For whole term	14	09	14	.003	12	12	.890	9	15	.000*
Lack of money for school fees	40	32	44		38	38	.966	33	43	.000*

Table 10 shows that 85% of the rural children were currently schooling as against 90% of the urban children and 84% of the semi-urban children. Close to half (44%) of the rural children reported that they had problems in paying their school fees while 40% and 32% reported lack of money to pay school fees in urban and semi-urban respectively. The same proportion of males and females reported lack of money to pay school fees and ever missed school for a whole term. A higher percentage of males (87%) were currently in school than females (85%). In terms of age, greater proportions of children between ages 6-12 years were currently in school than children in ages 13-17 group. Similarly, children in ages 6-12 years were less likely to have missed school for a whole term and less likely to have problems of paying school fees than the older children.

5.3 Children Access to Education by Vulnerability

There is a significant difference in the children's access to education with non –orphans having more access than the orphans. Among categories of vulnerable children, children living with disabilities and double orphans have the least access to education.

The data showed that while 90% of the non-orphans were in school, only 79% of the orphans were currently attending school. Among the orphans, 82% of the single orphans were in school as against 68% of the double orphans. The data further revealed that a higher percentage (83%) of the paternal orphans were in school than the percentage (79%) of the maternal orphans in school. Within the group of other vulnerable children, those living with disabilities had the least percentage (65%) of the children in school and more likely to have problems in paying school fees. Similarly, orphans, double orphans and, maternal orphans were more likely to have missed school for a whole term and more likely to have problems in paying school fees than non-orphans, single orphans and paternal orphans respectively.

Table 11: Access to Education by Vulnerability

Vulnerability	Currently In School (%)	X^2	Ever missed school For whole term (%)	X^2	Lack of money For school fees (%)	X^2	School attendance dropped after death of parent (%)	Grade worsened after death of parent(s) (%)
Non orphan	90		11		33		NA	NA
All Orphans:	79	.000	15	.013	48	.000	23	13
Double	68		17		53		30	12
Single:	82		14		46		21	14
Paternal	83		12		50		22	14
Maternal	79		20		35		17	11
Other Vulnerable children:								
Living with disability	65		13		49		NA	NA
Living with chronically ill parent(s)	80		19		42		NA	NA
Living with old frail guardian	92		27		24		NA	NA
Living in HH an adult died recently	82		19		24		NA	NA

Note: NA = Not Applicable * Significant at P< 0.5

After the death of parents, double orphans and paternal orphans were more likely to drop out of school or record a drop in school attendance than single and maternal orphans respectively. On the other hand, the death of parent was more likely to affect negatively the school performance of single orphans and paternal orphans than the double and maternal orphans.

5.4 Findings from the Qualitative Data

The qualitative data collaborated most of the quantitative findings on children's access to education. Majority of the children reported that they were currently going to school. They only missed school when they were sick, when they did not pay school fees or when they did not have school materials. Few of the participants reported that they had to drop out of school after the death of their parents. A 12 year-old boy in urban plateau state said:

> " *Since the death of my father, I left formal education to informal education (Quranic School) far away from my state"*

Some of the caregivers promised to send them to school but they never fulfilled the promise. In the words of a 12 year-old girl:

> *"I left home with the intention and promise that I will be in formal school but till this present moment I have not been enrolled in formal education"*

Some of the participants with disabilities reported that they did not have disability-friendly schools which had affected their performance and progress in school. But there was a 7 year-old girl in urban community in Niger State who despite her severe physical disability was still doing well educationally because she had very good family support and a disability- friendly school. She reported that her teacher often took time to give her extra lessons. This helped her to perform comparably well with her peers without disabilities despite the fact that she often missed school to go to see a specialist doctor at the hospital.

Most of the children (13-17 years) said they were currently going to school but some of them had to drop out of school because they could not pay school fees or get school materials. Majority of those that were going to school reported that they missed school often and sometimes went late to school for various reasons which include:

- Often had to go to farm early in the morning before going to school
- Sometimes engaged in hawking for economic support of the family

- When they were sick
- Some had to stay at home to take care of younger siblings when surviving parent had to go to market or work

One of the participants in rural FCT said:

"I used to go to school often but since the death of my father, I stopped going because of school fees"

Another participant who reported on behalf of others in her condition said:

"We are usually sent back from school because of inability to pay school fees. We are beaten with sticks up to the streets so as to go home."

However, there were no reported cases of maltreatment in school.

Majority of the children who had to drop out of school or lost their parents early in life and never went to school, were unhappy that they were not in school. A 17-year-old boy who was a motor mechanic apprentice felt very sad because he did not have opportunity to attend a formal education. He lamented:

"Please if there is any way you can help me to learn to read and write, please help me. I cannot even write my name or read at all. I always feel sad about this. I don't even mind starting primary one now".

However, few others said that they did not want to go to school. For example, A 17 year old boy in rural area community of Niger State expressed his preference for farming instead of going to school. He said in Hausa:

"Ba na so nje makaranta. Ina da dan gona na wanda za mnoma msamu kudi m sayi baburu na yin haya da shi sabo da neman kud"'

Meaning:

"I don't want to go to school, I have my own little farm land that I cultivate, So that when I make money I will buy motorcycle which I will use to make money"

Those that were currently learning a trade or vocation complained that they did not have support and they were worried about getting financial assistance to set up their vocation at the end of the training. Those that were in school would want support directly from organizations, government and individuals in the following areas:

- Payment of school fees
- Establishment of special schools for orphans and other vulnerable children
- Giving direct financial support to them without passing through anybody
- Setting up extra lessons or extra classes for them

5.5 Programmatic Implications

The fact that overwhelming majority of the children (including orphans) were in school shows that a school based intervention has potential of reaching majority of the orphans. As expected, double orphans had the lowest school enrolment rate and highest proportion of children having no money to pay school fees. Priority should be given to double orphans in the provision of educational assistance. Low economic status of mothers may also be responsible for the high proportion reporting lack of money for school fees and high rate of drop-out among paternal orphans after the death of their fathers (who was the person providing the money). Hence, education interventions for orphans should not only concentrate on orphans currently in school but, should also re-enroll those who dropped out of school after the death of their parents.

SECTION SIX: HEALTH STATUS OF THE CHILDREN

The purpose of this section is to assess general health status of the children and to evaluate their access to health care treatment. All children, especially OVC, require support for survival in term of health care. Access to preventive, curative and rehabilitative health care is an important program area for orphans and vulnerable children.

6.1 Health Status of the Children by State

Table 12: Health Status of the Children by State

Health Status	FCT N=162 (%)	Benue N=437 (%)	Nassar N=279 (%)	Niger N=530 (%)	Kad N=674 (%)	Plate N=337 (%)	Kogi N=322 (%)	Edo N=345 (%)	Total N=3086 (%)
Fell sick in the last 3 months	72	72	83	80	71	74	83	73	76
Causes of the last sickness:									
Malaria	49	39	13	34	37	39	36	47	37
Diarrhea	07	05	03	03	06	07	02	02	04
Cold/Catarrh	08	12	04	11	10	10	07	06	09
Others	11	20	09	09	19	29	07	09	15
Have very good health status	16	29	29	31	40	26	26	25	30

More than three-quarter (76%) of the children reported that they fell sick in the last three months. The incidence of sickness was highest in Nassarawa and Kogi states (83% each) while Kaduna state recorded the lowest incidence of illness among the children. The results further showed that for those who fell sick, the major cause of illness was malaria averaging 37% for all the states. The FCT, Edo, Benue and Plateau states reported more cases of malaria. Other causes of sickness reported were cold or catarrh, and diarrhoea. During the last episode of sickness, close to one-quarter (22%) of the children access treatment from patent medicine store/chemists, 16% received treatment from private hospital, 10% were treated at the general hospital while 13% did not receive any treatment. Thirty percent of the children rated their health status as “very good”. Children in Kaduna state claimed to be more healthy (40% had very good health status through self assessment) than children from other states while children from FCT reported lowest percentage (16%) of very good health status.

6.2 Health Status of Children by Residence, Sex and Age

The data showed that there was a significant difference between the health status of children in different communities. Children in the urban communities appeared to have better health status than semi-urban and rural children.

Table 13: Health of Children by Residence, Sex and Age

	Residence				Sex			Age		
Issues	Urban (%)	Semi urban (%)	Rural (%)	X^2	Male (%)	Female (%)	X^2	6-12yrs (%)	13-17yrs (%)	X^2
Fell sick in the last 3 months	54	61	56	.000	57	57	.581	57	58	.052
Have very good health status	31	25	36	.000	29	31	.007	28	32	.000
Causes of last sickness:										
Malaria	36	35	41		37	36	.753	36	38	
Diarrhoea	04	04	06	.000	04	04		05	04	
Catarrh	10	06	13		09	10		09	10	.004
Others	18	13	14		15	15		14	15	
Problem of poor Health	08	08	11	.000	10	9	.959	08	10	.000

Table 13 above, shows that children in the semi-urban communities were more likely to fall sick and less likely to report very good health status while, those in the rural communities were more likely to report problem of poor health. Malaria, diarrhoea and catarrh were more prevalence in the rural communities.

There was no significant gender variation in the percentage of children reported been sick in the last 3 months but, females reported very good health status than males. The data also showed that there was no significant difference in the types of sickness experienced by both boys and girls but, slightly higher (10% vs 9%) proportion of boys reported having poor health problems than girls.

The proportion of children who reported been sick during the last 3 months was the same for ages 6-12 and 12-17 groups and there was no difference in the types of health problem they experienced. However, more (32%) of the older children reported having very good health status than younger children (28%) while, lower percentage of younger children had problems of poor health.

6.3 Health Status of Children by Vulnerability

Generally, non-orphans appeared to have better health status than orphans. The data showed that while 56% of the non-orphans reported falling sick in the last month, 60% of the orphans fell sick; 33% of non-orphans reported very good health as against 23% of the orphans and; 8% of non-orphans reported having problem of poor health compared with 10% of the orphans. Within the orphan group, higher percentage of single orphans reported falling sick in the last 3 month and higher proportion reported having problem of poor health than double orphans. On the other hand, paternal orphans were more likely to fall sick in the last 3 months, more likely to have problem of poor health status and, more likely to report less access to health care services after the death of their father than the maternal orphans. Among all other vulnerable children, children living with old frail grand parent/guardian reported highest percentage (76%) of children who fell sick in the last 3 months and highest percentage (36%) reporting poor health problems.

Table 14: Health Status of the Children by vulnerability

Vulnerability	Fell sick in the last 3 months (%)	X^2	Have very good health status (%)	X^2	Problem of poor Health (%)	X^2	Less access to health care after the death of parents (%)
Non orphan	56		33		08		NA
Orphans:	60	.101	23	.000	10	.000	18
Double	59	.151	21	.000	08	.000	29
Single:	60		24		10		14
Paternal	60	.000	25	.000	10	.000	14
Maternal	58		23		09		12
Other Vulnerable children:							
Living with disability	71	.000	15	.000	11	.016	NA
Living with chronically ill parent(s)	72	.000	38	.000	26	.000	NA
Living with old frail guardian	76	.000	51	.000	36	.000	NA
Living in HH an adult died recently	45	.000	30	.000	16	.000	NA

6.4 Findings from the Qualitative Data

Majority of the children in age 6-12 group reported that they did not fall sick often. When they fell sick, the major causes of sickness were identified as: malaria, stomach ache, yellow fever, typhoid, pneumonia and fever. Most of the participants said that their parent or guardian normally treated them at home when they fell sick. Few of them that were taken to hospital when they sick reported that their caregivers usually paid for the treatment

A boy in the group who had Sickle Cell Anaemia said:

> **"***I am a sickler and sometimes my bones will be paining me. My mother will boil water and massage and apply the medicine called "now" "now".*

Majority of the participant in older children group believed that orphans hardly fall sick because God was the one caring for them. One of the girls in the group said:

> *"It is rare for an orphan to be seriously sick because God usually give special protection to the child, we don't often get sick"*

The participants reported that when they fall sick, the usual places for treatment were home and medicine store/chemist. Some of the children reported that they often treated with herbs at home by their caregivers. When they visited chemist or hospital, their caregivers usually paid for the treatment. Very few of them reported that they went to the hospitals for treatment.

6.5 Programmatic Implications of the Findings

The results confirmed the findings of other studies that malaria is the major cause of sickness among children in Nigeria. It also validated the fact that patent medicine stores/chemists (apart from home remedies) is usually the first and (in most cases) the only port of call for treatment. Hence, health intervention program should focus on malaria prevention (such as provision of mosquitoes treated nets, malaria prophylaxis etc) in collaboration with patent medicine dealers.

SECTION SEVEN: FOOD INTAKES OF THE CHILDREN

Adequate nutrition for children remains an important concern in Nigeria. Many households caring for children often lack access to nutritionally adequate food and have chronic food insecurity. This often leads to poor growth and development in children. Poor nutrition is also a major predictor of child morbidity.

7.1 Food and Nutritional Intakes of the Children by State

Table 15: Food and Nutritional Intakes of the Children by State

Nutritional Intakes	FCT N=162 (%)	Benue N=437 (%)	Nassar N=279 (%)	Niger N=530 (%)	Kaduna N=674 (%)	Plateau N=337 (%)	Kogi N=322 (%)	Edo N=345 (%)	Total N=3086 (%)
Insufficient food as a problem	10	14	42	22	10	21	26	27	20
Always eat at least 3 times a day	86	45	32	60	83	80	69	58	65
Takes protein regularly	33	25	17	27	18	14	39	32	25
Eats food to satisfaction always	53	51	47	51	73	55	58	54	57

A fifth (20%) of the children identified insufficient food as the major problem confronting them. Highest rate of insufficient food (27%) was reported by the children in Edo state and lowest rate was reported among children in FCT and Kaduna states. Almost one-third (65%) of the children reported that they ate at least 3 times a day. One quarter of the children reported that they take meat/fish/egg or other forms of protein regularly. Regular protein intake was highest (39%) among children in Kogi and lowest (14%) among respondents in Plateau state. Generally, more than half (57%) of the children reported that they always ate food to satisfaction. Children in Kaduna state (73%) ate food to satisfaction more than children in other states. Ironically, children from the "food basket" (Benue state) reported one of the lowest rate (51%) of eating to satisfaction, second only to Nassarawa state.

7.2 Food and Nutritional Intake of Children by Residence, Age and Sex

Children in the rural areas appeared to have a better food intake than children in urban and semi-urban areas. About 76% of the children in rural areas usually ate at least 3 times a day and 62% of them always ate to satisfaction. However, the protein intake of the children in rural areas was the lowest (21%) when compare to the children in urban (26%) and semi-urban (25%) areas.

Table 16: Food and Nutritional Intake of the Children by Residence, Sex and Age

Issues	Residence				Sex			Age		
	Urban (%)	Semi urban (%)	Rural (%)	X^2	Male (%)	Female (%)	X^2	6-12yr (%)	13-17yr (%)	X^2
Always eat at least 3 times a day	67	55	76	.000	66	64	.232	66	64	.331
Takes protein regularly	26	25	21	.000	23	26	.103	23	26	.058
Insufficient food as a problem	18	24	18	.000	21	20	.613	20	21	.000
Eats food to satisfaction always	59	51	52	.000	56	58	.132	57	57	.085

The data on food intake of boys and girls did not show any significant difference, but the girls appeared to have a slightly better nutritional intake index than boys. Table 16 shows that although, 66% of boys (against 64% of girls) always ate at least 3 times daily, higher percentage of girls ate protein regularly and ate food to satisfaction more regularly than boys. Less proportion of girls also reported insufficient food as a problem.

Children in age 6-12 and 13-17 groups had similar pattern of food intake. Both younger and older children had same proportion reported to always eat food to satisfaction. However, younger children were more likely to eat 3 times a day and less likely to have problem of insufficient food than the older children. But, older children ate protein more regularly than the younger children.

7.3 Food and Nutritional Intakes of the Children by Vulnerability

Non-orphans had better food and nutritional intakes than the orphans. Non-orphans were more likely to eat at least 3 times daily, more likely to take protein regularly, more likely to eat food to satisfaction and less likely to report insufficient food as a problem than the orphans.

Table 17: Food and Nutritional Intake of the Children by Vulnerability

Vulnerability	Always eat at least 3 times a day (%)	X^2	Takes protein regularly (%)	X^2	Insufficient food as a problem (%)	X^2	Eats food to satisfaction always (%)	X^2
Non orphan	67	.000	29	.000	18	.000	65	.000
Orphans:	59		16		25		40	
Double	52	.000	08	.000	23	.013	29	.000
Single:	61		19		26		44	
Paternal	57		19		28		43	
Maternal	74		20		19		49	
Other Vulnerable children:								
Living with disability	71		13		16		54	
Living with chronically ill parent(s)	58		12		31		57	
Living with old frail guardian	40		20		56		48	
Living in HH an adult died recently	61		18		24		69	

There was a significant difference in the food and nutritional intakes among different types of orphans, with double orphans and paternal orphans more vulnerable than single and maternal

orphans respectively. The data showed that 52% of double orphans always eat 3 times daily, 8% were taking meat/fish/egg or other proteins regularly and less than one in every five (29%) always ate food to satisfaction. Double orphans were almost 4 times less likely to take protein and more than 2 times less likely to eat to satisfaction than non-orphans. Paternal orphans were less likely to eat 3 square meal daily, less likely to take protein regularly and less likely to eat to satisfaction always than maternal orphans.

7.4 Programmatic Implication of the Findings

Generally, the pattern of food intakes of all the children was below the standard. Protein intake was particularly poor. Variations in food intakes by state, by type of orphans and by residence were noted. Ironically, maternal orphans and children in the rural areas reported better food intakes. Since food intake is a joint (household) decision, nutrition intervention should focus on all children irrespective of their orphan status.

SECTION EIGHT: EMOTIONAL AND PSYCHOSOCIAL WELL BEING

8.1 Emotional and Psychosocial Problems of the Children by State

The data showed that a number of children exhibited different indices of emotional and psychosocial problems.

Table 18: Emotional and Psychosocial Problems by State

Emotional well-being	FCT N= 162 (%)	Benue N=437 (%)	Nass N=279 (%)	Niger N=530 (%)	Kad N=674 (%)	Plate N=337 (%)	Kogi N=322 (%)	Edo N=345 (%)	Total N=3086 (%)
Had scary dream in last 2 weeks	22	30	16	21	35	40	20	25	27
Have scary dreams often/always	04	09	11	06	05	15	06	04	07
Feel sad often/always	01	09	17	14	03	04	10	10	09
Feel happy often	42	30	15	27	36	16	16	26	27
Fight with others often/always	03	06	09	03	02	03	02	04	04
Prefer to be alone often/always	03	06	11	07	02	04	05	05	05
Often feel worried	01	06	08	05	03	12	02	03	06
Often feel frustrated	03	06	05	06	02	02	04	04	04
Often become easily angry	03	08	12	14	06	03	17	10	09
Feel hopeful about the future often	42	32	27	27	29	21	37	39	31
Had trouble falling asleep in last 2 weeks	11	19	04	11	20	17	11	11	14

More than one-quarter of the children in all states had experienced scary dreams in the last 2 weeks. Children in Plateau state reported highest incidences (40%) of scary dreams in the last 2 weeks while children in Kogi state had the least incidence. About one-tenth (09%) of the children reported that they often feel sad while a little more than one-quarter of the children felt happy always. Less than one-third (31%) of the children reported that they often felt hopeful about the future. Children in FCT reported that they felt hopeful about the future more than children in other states.

8.2 Emotional and Psychosocial Problems of the Children by Residence, Sex and Age

Table 19 shows that urban children were more likely to exhibit emotional and psychosocial problems than rural children. Urban children were more likely to have scary dream often, more likely to feel unhappy, more likely to feel worried often, less likely to feel hopeful about the future and more likely to have ran away from home than rural children. On the other hand, semi-urban children were more likely to feel unhappy and more likely to have run away from home than children in urban and rural communities.

Table 19: Emotional and Psychosocial Problems of the Children by Residence, Sex and Age

	Residence				Sex			Age		
Emotional problems	Urban (%)	Semi urban (%)	Rural (%)	X^2	Male (%)	Female (%)	X^2	6-12yrs (%)	13-17yrs (%)	X^2
Have scary dream often	08	08	06	.000	07	08	.416	07	07	.001
Feel unhappy often	06	13	04	.000	08	09	.275	08	09	.000
Feel happy often	30	25	25	.000	27	27	.364	28	26	.000
Prefer to be alone	05	05	06	.000	05	05	.049	04	06	.000
Feel worried often	05	07	03	.002	04	06	.298	05	05	.000
Feel hopeful about the future often	27	28	40	.000	31	31	.234	29	33	.000
Had problems falling asleep in last 2wk	14	14	15		14	15	.650	15	13	.000
Ever ran away from home	17	32	09	.000	21	20	.947	21	21	.985

The data further revealed that, although the differences were not significant, girls were more likely to exhibit emotional and psychosocial problems than boys. For example, girls were more likely to have scary dreams often, more likely to feel unhappy, more likely to feel worried and more likely to have problems falling asleep than boys. But, boys were more likely to have run away from home than girls.

8.3Emotional and Psychosocial Well-being by Vulnerability

Orphans were significantly more likely to have emotional and psychosocial problems than non-orphans. For most of the emotional and psychosocial indices, double orphans were more likely to exhibit negative emotional tendencies than single orphans. For example, double orphans were more likely to have scary dreams/nightmares, felt unhappy more often, less likely to feel happy, more likely to prefer to be alone instead of playing with other children, more likely to feel worried and more likely to feel frustrated than other single orphans.

Table 20: Emotion and Psychosocial Problems of the Children by Vulnerability

Vulnerability	Have scary dream often (%)	Feel unhappy often (%)	Feel happy often (%)	Prefer to be alone (%)	Feel worried often (%)	Feel hopeful about the future often (%)	Had problems falling asleep in last 2wk (%)	Ever ran away from home (%)
Non orphan	06	08	31	04	03	32	12	20
Orphans:	10	10	18	06	10	28	19	23
X^2	.000	.000	.000	.002	.000	.002	.000	.076
Double	15	12	19	10	18	22	28	23
Single:	08	09	18	05	10	30	16	22
Paternal	08	10	17	06	07	29	17	24
Maternal	06	06	22	04	07	33	15	16
X^2	.000	.055	.001	.024	.000	.000	.000	.000
Other Vulnerable children:								
Living with disability	18	07	23	04	15	18	21	29
Living with chronically ill parent(s)	22	11	15	15	15	32	19	32
Living with old frail guardian	20	12	04	32	20	36	04	52
Living in HH an adult died recently	03	03	37	03	11	40	16	24

Among the single orphans, paternal orphans exhibited emotional problems more often than maternal orphans. For example, paternal orphans have scary dream more often (8% vs 6%), felt unhappy more often (10% vs 6%), felt happy less often (17% vs 22%), preferred to be alone instead of playing with other children more often (6% vs 4%) than the maternal orphans. However, both maternal and paternal have the same tendency to feel worried.

8.4 Findings from the Qualitative Data

Most of the FGD participants in the children groups said that they normally discussed with their surviving parents or guardians whenever they had problems. Some of the children that were living with their step mothers said they preferred to discuss their problems with their siblings while some others simply prayed about it. They reported that they felt happy when the problems were resolved and it was not solved, they just kept hoping it would be resolved some day.

The problems they usually encounter included:

a. ***Emotional Problems***- including harassment of their mothers by family members; abandonment after the death of their parents; emotional trauma whenever they were accused and punished wrongly; blames for any unfortunate thing that happened in the family; had to move from one family member to another and exposure to variety of maltreatment by the family members and guardians:

   A girl in semi-urban community in Benue state said:

   "My father died in 1998 and my mother who was accused of killing my father also died in 2002. There is nobody to pay my school fees"

   A 12 year old girl in Nasarawa state said:

   "If I don't do anything and you beat me, l start crying remembering my father"

   A 15 year old girl in semi-urban community in FCT shared the experience of how a friend of hers was maltreated:

   "I have a friend who was not living with her parents (an orphan); she was living with her aunty. On market days, she is sent to the market to hawk, when she returns, she will not be given food, and she was not sent to school. One day while she was returning from the market she had an accident with a motorcycle and she had bruises. Her Aunty did not treat her and was hostile and said she was careless and was playing on the road for the motorcycle to have hit her. The aunty later sent her away from her house and l don't know where she is currently"

They were also exposed to other emotional problems emanating from running errands at late hours, having no one to talk to, not able to visit friends, not able to accept parent's death and not being able to discuss with the guardian like the parent(s).

b. Social Problems- including sexual and physical harassment by neighbors and peers
c. Educational Problems- such as difficulties in getting money to pay school fees and other school materials; being forced to miss school in order to do house chores or hawk to supplement family earnings and some had to drop out of school because of lack of funds to continue education. Some of those that lost their parents in early childhood, never got opportunity of attending school at all
d. Recreational Problems- including not having time or material to play and inability to get gifts as they used to when their parents were alive

e. Health Problems- those living with guardians might not get adequate care when they are ill.
f. Nutritional Problems- including insufficient food; imbalanced and irregular meals
g. Poor Clothing- many children complained of not having good clothes. Some of them were worried about Christmas or festivity clothes. At festive periods their guardians did not buy them clothes, shoes and other accessories that they bought for their own children. For instance a child in Kaduna state said:
"I don't have cloths, look at what l'm wearing, it's tattered".

Majority of these problems came after the death of their parent(s) or when they started living with people other than their parents. The participants agreed that the problems of orphans were more enormous and peculiar when compared to non-orphans. According to the children, most of the problems mentioned above were not resolved but some of them had developed coping strategies which includes:

- Getting assistance and help from non-governmental organizations like: CRS, religious groups such as St. Vincent the Paul, Parish Action Committee on HIV & AIDS of the Catholic Church, a group from Mecca etc surviving parents, relations and philanthropic individuals
- Getting an elderly person in the neighborhood to beg the guardian whenever they were accused of wrong doing.
- Taking up economic generating activities like hawking to meet their financial needs

Many of the children reported that they discussed with their surviving parents, siblings, friends, relations, grandparents, pastors or imams whenever they had problems such as: school fees, school materials, feeding and need for medical care. A number of them said they discussed spiritual problems with their pastors.

Other vulnerable children that might be experiencing similar difficult situations like the orphans were identified to include disobedient children, children that had poor parents, children with disabilities (who are begging on the street,) street children and Almajiris. On what could be done to improve their conditions, the children identified the need for support in the following areas:

- School fees and materials, while those that dropped out of school would like to go back to school
- Feeding and Clothing
- Comfortable homes
- Reduction of emotional stress

Similarly, the participants in the caregivers group mentioned that the following problems were being experienced by orphans and other vulnerable children in the communities:

- Food shortage
- Poor access to drinking water
- Poor accommodation- they shared a small space with so many people. Some of them were asked to vacate their parents' homes or made to move from one family member to another. Some were living on the streets, as they did not have a home.
- Lack of good Clothing
- Lack of access to education and some dropped out of school
- Ill health and limited access to medical care
- Family instability as a result of divorce and separation of parents
- Stigma and discrimination from community members

- OVC were always the first suspects whenever there was any criminal act in the community
- Poverty (No money)
- Difficulty in character formation of children in terms of moral and spiritual upbringing especially for single parents
- Lack of assistance in securing jobs or start/establish vocations or trade.
- Girls often lured into prostitution and boys into armed robbery and cultism
- Nobody to advise the children.

The participants agreed that the highlighted problems were affecting orphans and other vulnerable children more than children whose parents were alive. Other children who might be experiencing similar problems were those whose parents were very poor or those who lived in polygamous homes. The participants suggested the following ways to address some of the problems:

- Individuals in the communities should be made to assist the OVC
- Religious groups should be encouraged to assist OVC and their caregivers
- People should pray for God's intervention
- Government should provide supports, create jobs, scholarships and so on for OVC and their caregivers
- Local and international agencies should provide technical and financial assistance to individuals and the community for OVC care and support especially in the areas of education, feeding and health.
- Provision of orphanages. However they preferred that the extended family structures be strengthened and supported

SECTION NINE: CHILD RIGHTS AND PROTECTION ISSUES

This section provides information on several critical issues related to child labour and abuse, sexual coercion and birth registration which would help to design interventions to protect children from harm, to assist them when affected, and to promote their overall development.

9.1 Incidence of Child Rights and Protection Violations

Table 21: Child Abuse, Right and Protection Issues

Abuse and Right Issues	FCT N=162 (%)	Benue N=437 (%)	Nassa N=279 (%)	Niger N=530 (%)	Kad N=674 (%)	Plat N=337 (%)	Kogi N=322 (%)	Edo N=345 (%)	Total N=3086 (%)
Child Labour: Ever worked for money	22	38	40	37	27	49	28	26	33
Ever forced to work for money	09	19	29	19	13	16	13	13	17
Child Abuse: Ever beaten for refusing to run errand	29	39	20	19	26	28	18	22	25
Ever chased out of home	02	06	28	13	04	06	16	15	10
Ever had sexual intercourse against will	04	12	15	08	19	09	07	06	10
Child Right Issues: Knowledge of own date of birth	34	22	14	14	17	38	47	40	28
Have birth certificate	31	21	25	16	24	28	46	35	27
Knowledge of law child protection law	20	50	44	36	25	23	53	36	36

The findings of the study on child safety and protection revealed that a third (33%) of the children had ever worked for money, 22% of them had ever worked for food or other gift items, while about one-in- five (17%) of the children reported that they had ever been forced to wok for money. Incidence of child labour was highest (49%) in Plateau and lowest (22%) in FCT. A quarter (25%) of the children reported that they had been subject to corporal punishment for refusing to run errands while 10% of the children had ever been chased out of home.

The study further assessed the knowledge of the children about the child protection law and found that a little more than one-third (36%) of the children reported knowledge of the child protection law. More than a quarter (27%) of the children had birth certificate, and 28% of the children could mention the day, month and year of their births. One out of every ten (10%) of the children aged 13 to 17 years reported that they had ever had sexual intercourse against their will. The breakdown by states indicated that Kaduna had highest number of children (19%) who had sexual intercourse against their will while FCT recorded lowest incidence of sexual coercion.

9.2 Incidences concerning Rights and Protection of Children by Residence, Sex and Age

Table 22: Safety, Rights and Protection Issues by Residence, Sex and Age

	Residence				Sex			Age		
Issues	Urban (%)	Semi urban (%)	Rural (%)	X^2	Male (%)	Female (%)	X^2	6-12yrs (%)	13-17yrs (%)	X^2
Ever worked for money	32	38	29	.002	36	31	.039	25	42	.000
Ever worked for food/gift	22	23	22	.000	23	21	.355	19	26	.000
Ever forced to engage in economic activities	15	18	16	.058	18	16	.341	15	18	.031
Ever beaten for refusing to run errand	31	23	21	.000	25	25	.447	27	23	.000
Ever been chased out of home	08	16	06	.000	11	10	.836	08	13	.000
Knowledge of own date of birth	24	27	32	.000	27	29	.782	23	34	.000
Have birth certificate	30	21	30	.000	26	27	.588	21	33	.000

Incidence of children being required to work was higher in semi-urban areas than rural and urban areas. The data showed that 18% of the semi-urban children reported ever been forced to engage in economic activities whereas 16% and 15% reported the experience among the rural and urban children respectively. Although not significant (P>.001), the data also showed that semi-urban children were more likely to have worked for money and worked for food/gift than urban and rural children. Rural children were less likely to have been subjected to corporal punishment for refusing to run errand and less likely to have been chased out of home than urban and semi-urban children. Also, children in the rural areas were less likely to have knowledge of child protection law than urban and semi-urban children.

Almost in all cases of child rights and protection that were examined, the data showed that boys were more vulnerable than girls to violations. Higher percentage of boys than girls reported ever worked for money (36% vs 31%), ever worked for food/gifts (23% vs 21%), and ever been forced to engage in economic activities (18% vs 16%). It was also noted that higher percentage of girls had knowledge of their birth dates and higher percentage of girls had birth certificates than boys. However, the difference between boys and girls in all cases of child rights and protection were not significant (P>.05).

The data further showed that older children (aged 13-17) were more likely to be abused and required to participate in economic activities than the younger children (aged 6-12). Close to half (42%) of the older children had ever worked for money while a quarter of the younger children had ever worked for money. However, younger children were more likely to be subject to corporal punishment for refusing to run errand than the older children.

9.3 Incidences of Child Abuse and Exploitation of Children by Vulnerability

Orphans were significantly more vulnerable to abuse and exploitation than non-orphans. The data shows that 29% of the non-orphans and 42% of orphans had ever worked for money, 18% of orphans and 31% of non-orphans had worked for food or gifts, 15% of non-orphans and 20% of orphans had ever been forced to engage in economic activities. As a form of personal identity, non-orphans were also more likely to know their birth dates and were more likely to have birth certificates than the orphans.

Table 23: Child Abuse, Right and Protection Issues by vulnerability

Vulnerability	Ever worked for money (%)	Ever worked for food/gift (%)	Ever forced to engage in economic activities (%)	Ever beaten for refusing to run errand (%)	Ever been chased out of home (%)	Knowledge of own date of birth (%)	Have birth certificate (%)
Non orphan	29	18	15	25	11	29	28
Orphans	42	31	20	25	09	26	23
X^2	.000	.000	.000	.070	.054	.000	.018
Double	52	31	24	29	08	19	13
Single:	39	31	19	24	09	28	27
Paternal	40	33	20	22	08	27	26
Maternal	36	26	17	31	10	31	31
X^2	.003	.001	.000	.026	.107	.000	.000
Other Vulnerable children:							
Living with disability	42	26	15	16	06	21	18
Living with chronically ill parent(s)	37	27	28	29	11	20	25
Living with old frail guardian	48	48	48	32	20	24	40
Living in HH an adult died recently	34	26	08	16	04	26	05

Among the orphans, double orphans were more likely to have worked for money, worked for food/gifts, forced to engage in economic activities and less likely to know their dates of birth. Paternal orphans were the second most vulnerable group (after double orphans) in terms of child labour and rights. The data showed that the paternal orphans were more likely to have ever worked for money and for food/gifts and forced to engage in economic activities than the maternal orphans. The paternal orphans were also less likely to know their birth dates and less likely to have birth certificates than the maternal orphans. However, there was no significant difference among types of orphans in terms of experience of being chased out of home. It also worth noting that higher proportion of maternal orphans knew their birth dates and had birth certificate than other groups including non-orphans.

Within the group of other vulnerable children, children living with old frail grand parent or guardian were more likely to engage in child/forced labour and more likely to have been chased out of home. Children living with old frail guardian were almost 2 times more likely to have worked for food than other vulnerable children, 3 times and 5 times more likely to have engaged in forced labour than children living with disability and children living in households where a chronically ill adult died recently (respectively). However, children living with frail guardian were more likely to have birth certificates than other groups of children.

9.4 Findings from the Qualitative Data

The opinions of most of the participants in children group slightly differ from the results of the quantitative data. They believed that double orphans and maternal orphans were cheated and maltreated more than the paternal orphans, especially by their extended family members. According to the participants, maternal orphans suffered more when they lived with their step-mother or with extended family members. Most of the paternal orphans that lived with their grandparent(s) or whose father did not remarry received better treatment. Some of the participants said that the orphans were usually maltreated and discriminated against in the communities because the people knew they did not have anybody to defend them or care about them. For example a 15 year-old out-of-school girl in rural Niger State said:

> "Kurun, muna ma mutane tarle, ama ba su a bamu wani abu maiyawa ba. Mba mu yi tarle ba, bam u a samu abinci. Dan kudi wanda muna samu yana tamaikye mu"
> *Meaning: "We often hawk for people, who will give us meager money and if we do not hawk we will not feed fine, hence the money from hawking is for our own survival"*

Some of the children reported that they were chased out of the house when they quarreled with their guardian's children or did something wrong. Some of the participants also observed that orphans with disabilities were made to beg on the street whereas other children (non orphans) were been given special attention by their parents.

Some of the children reported that there were no measures to check abuse in the community, quoting a boy from the group:

> *"Sometimes even though you report to some of the elders, they would not have the courage to go and meet the person that abused on"*

Hence, in many instances, the children did not bother to report since they knew it would not yield any positive result.

However, some participants reported that those who cheated orphans were sometimes challenged by the neighbours. A few of the children said they had never been cheated or maltreated, some of them even said they were treated better now after the death of their parents. A girl in the group said:

> *"In our community, some people usually stand to protect the rights of the orphans. I know of a specific person who can't tolerate the abuse of orphans"*

Some participants in the caregivers' group reported that orphans were sometimes cheated in the sharing of their parents' properties, especially by close family members. One participant asserted that God protects orphans so if adults cheated them, God has a way of punishing such adults. However, the participants observed that in most cases, community members did not interfere when orphans were cheated because such matters were regarded as family matters.

Case Study 2: Orphans are Vulnerable to Abuse, including Sexual Abuse

Happiness (not real name) is a 13-year-old girl, and student of Junior Secondary School (JSS) 2 of a government secondary school in Lafia, Nasarawa State. Her father died some years ago, after which her mother remarried. She now lives with her mother and her stepfather in Lafia. She was raped on 20 January 2007 by a neighbor (name withheld) who was HIV positive. In her words:

> ***"I used to help his family to take care of their baby before the baby con die. On the fateful day, he sent me to buy mobile phone recharge card for him, when I came back, he happens to lock the door, before I opened my mouth he decided to push me on the bed, already he has opened radio (CD), the volume up is opened. I'm shouting nobody to help, and I decided to call my Jesus. He is the one that set me free. Later on, I am shouting Jesus, nobody to help. I decided to be shouting Jesus, shout, help, somebody help me. Then, later on my legs, na hin my leg con dey heavy then I decided to push him. He fell down and I rushed the door well, the door open and rushed to tell my mum (Crying). His girlfriend came the time I was shouting, she's knocking the door, I'll still shouting, weather she no heard or not I don't know…… (Crying). My Jesus set me free from the hands of the man, nobody came in I am the one that opened the door…….. "***

After the incidence, Happiness's mother called the police quietly without the man knowing. The police picked up the man while he was begging her mother claiming it was devil that pushed him into doing it. He was later charged to court.

The girl was taken to the hospital where she was given HIV prophylactic drugs for 7 days. Happiness now lives in fear of possible HIV infection. "I fear because of sickness," she said.

On the other hand, most of the traditional rulers claimed that appropriate sanctions were usually meted unto those who maltreated orphans. If a case of maltreatment was established, the family might withdraw the child from the guardian and transfer him/her to another person within the extended family. For example, according to one Tiv traditional ruler:

> *"Aluer or tambe wanchoov yo ityo i a de nan ga, a na nan mtsaha,"*
> English interpretation: *"if any body bewitches an orphan the community will not allow it, but punishes the person"*

A Muslim leader said that Islamic religion frowns at cheating an orphan. According to him a child could only cheat himself by being naughty. However, most traditional leaders agreed that issues about abuse of orphans were handled at the family level. Some of the leaders also observed that there were no structures in place in the community to take care of cases of abuse and people hardly report such cases to the community leaders.

9.5 Will and Inheritance

Many children reported that they were not aware of any Will written because they were young when their parent(s) died. For those that were old enough to know, they reported that Wills were not usually written but verbal instructions were left to guide the children on how to share the properties. They said, most of the time the verbal instructions were not respected. However, there was little departure from this; according to a boy in the group:

> *"My father left instructions on how his property should be shared and it was respected".*

Some of the participants said, their parents discussed with them before they died. Most of the discussions centered on property sharing and advice on how to be of good behaviour. However, in the absence of a Will, culture and traditions have stipulated how properties of a deceased person should be shared.
The children identified the following traditions in sharing deceased parents' property:

- In many communities, the eldest son inherits the property of a dead man. In some communities, the eldest daughter inherits the properties where there are no sons. In some other communities the property is given to the wife. In all cases, whoever inherits the property is expected to take charge and cares for the other children.
- In polygamous setting, the property is shared among the first sons of all the wives. In some other communities, the property is divided according to the number of wives and each wife with her children takes equal share.
- In Muslim communities, the Imams or and the relatives share property of the deceased to all the children, wives and relatives according to the Islamic injunction.
- The property of a dead woman is usually shared among her children and her younger siblings. If the children are young and the husband is alive, he takes charge. If the husband was deceased and the children are young, a relative of the deceased is appointed to take charge till the children become adult.

Some of the issues and problems the children encountered with regards to the sharing of their parents' property were:

- In some instances most of the properties would have been sold to offset debt (pay Medicare bills) during very difficult times (during parents' illness); so they might not have any property to inherit.
- Some of the relatives confiscated the property or quarreled with the children and their mothers over the property.
- Some of the children did not know what happened to the property because they were young when their parents died
- Sometimes the property were sold by the relatives without giving any money to the children
- Most of the children were not happy with the way their parents' properties were shared but they felt helpless about it.

Many caregivers agreed that few parents write Will or leave verbal instructions for sharing of property. In many communities, relations gather to share the property and the following characterizes the sharing of the property:

- Traditional method is used in sharing the property. The first male child usually inherits the property. In cases where there are no male children, the first female child inherits the property. Other children get their shares from their elder brother or sister. When the children are too young, the property is given to the father's younger brother to manage on their behalf until the eldest child becomes an adult. In many communities, widows are not allowed to inherit or manage their late husband's property. In some communities, the younger brother of the deceased 1 inherits the properties, including the wife and he takes care of the children.
- Among the Muslims, the Imam leads the family members and they use Islamic injunction to share the property among the children, wife(s) and relatives. All Muslims approved and agreed to this

- If a Muslim made a Will, it will be implemented depending on the percentage of assets he allocated to others who are not direct family members which must not be more than 30%; otherwise the Will would not be implemented and the Imams follow the Islamic injunction to share the property to all family members
- Among the Christians, the surviving spouse and the children are expected to inherit the property
- When verbal instructions are given, it sometimes includes instructions on their daughters' dowry, settlement of debts, land property, expected life style of their children and who cares for the orphans.
- The woman's property is shared among her children, her siblings and relations. In some communities, the husbands' inherits the properties of his wife.

Case Study3: Community Intervention Counts

Miss M is a 14 year old double orphan who lost her father and mother in 1991 and 2002, respectively. She is the second child in the family of 5 (3 boys and 2 girls). M's family hails from a community in the Idoma speaking area of Benue State. The household is now headed by M's elder sister who is 17 years old.

After the death of her father, their paternal uncles wanted to take some of the major assets including the 5 bedroom flat where they live currently. Fortunately, they have another uncle who intervened on their behalf and ensured they retained the house. The uncle also assisted them in pursuing their father's pension. Apart from the intervention of the uncle, the girl said she also believed that the spirit of her late father scared the uncles who were planning to take away their father's property from them.

Most of the community leaders said that people did not write Will. According to them, it was their role and responsibility to ensure that the property of the dead member of the community was shared evenly among children and wives. Where the deceased left a substantial property, a share would be given to his siblings. The property is usually shared according to the culture of the people. A traditional ruler in Benue State said that the family members sit together and share the property beginning with the eldest son. The eldest son's disposition on this issue matters a lot in what happens there after. Traditionally, a woman does not inherit her husband's property. According to the Hausa tradition (which follows the Islamic injunction), a traditional head in Kaduna said:
"It is the tradition and custom of the Muslims that after forty days the property of the late person is shared among the children and the wives".

9.6 Programmatic Implication of the Findings

The findings revealed that children engaging in economic activity to ensure their livelihoods was a major issue among the children, especially among the double orphans, paternal orphans and the males (boys). Most children worked as a coping mechanism for survival. Some of the children had to work to pay their school fees, feed themselves and the younger ones or to take care of their sick parents/frail grand parents. Others worked (fetch water, wash clothes, clean home and other household chores) for neighbours not for money but in exchange for food, clothing or other gift items. The focus group discussion also confirmed that many children were sent out by surviving parents and relatives to work in order to supplement family's income. Paternal orphans were more likely to engage in child labour because of the low

economic status of the surviving mothers. This result should be interpreted with caution because child labour in some cultural settings is not perceived as a negative phenomenon.

Household Economic strengthening intervention that targets the surviving mothers and guardians of double orphans may be one of the ways to reduce incidences of child labour. Older orphans (ages 15 and above) may also be trained on income generating skills/vocation to reduce the tendency of engaging in risky/strenuous activities. Majority of the children (orphans and non-orphans alike) did not know their birth dates and did not have birth certificates. It is part of the Survival Cluster of Rights of children to have birth certificate hence, intervention such as child birth registration campaign among parents and guardians are urgently required. Succession Planning should also be promoted among general population and among PLWA in particular to minimise incidence of conflicts in property sharing.

SECTION TEN: KNOWLEDGE, ATTITUDES AND PRACTICES ON HIV & AIDS

Attitudes towards PLWA and discrimination against them affect efforts to prevent transmission and to care for persons and families with HIV and AIDS.

10.1 Knowledge, Attitudes and Practice by State

The study found that the level of awareness of HIV & AIDS was still very low among the children interviewed. A little more than two-third (67%) of the children had heard of HIV & AIDS. Highest rate (76%) of HIV & AIDS awareness was recorded among the children in Benue State followed closely by Kogi and Plateau with 75%. The lowest rate of awareness of HIV & AIDS was recorded among children in FCT with less than a half of the children reported to have heard of the epidemics.

Table 24: Awareness of HIV & AIDS and Attitudes of the Children toward PLWHA by State

HIV & AIDS Awareness and Attitudes	FCT 161 %	Benue 437 %	Nassar 279 %	Niger 530 %	Kad 674 %	Plateau 337 %	Kogi 322 %	Edo 345 %	Total 3086 %
Ever heard of HIV & AIDS	49	76	68	55	65	75	75	73	67
Willing to eat from same plate with PLWA	14	28	43	35	20	34	34	30	29
Willing to care for a relative who is PLWA	39	58	55	56	48	67	63	53	55

An assessment of the attitudes of the children towards people living with HIV & AIDS showed that only 29% of the children were willing to eat will a person living with HIV & AIDS. More than a half of the children (55%) expressed their willingness to care for a relative who is living with HIV & AIDS. Children in FCT showed highest level of discriminating attitudes to the people living with HIV & AIDS.

Table 25: Knowledge of HIV Transmission and Prevention by State

Knowledge	FCT 162 (%)	Benue 437 (%)	Nass 279 (%)	Niger 530 (%)	Kad 674 (%)	Plate 337 (%)	Kogi 322 (%)	Edo 345 (%)	Total 3086 (%)
HIV Transmission: Sexual intercourse	24	38	33	33	26	42	43	17	32
Blood transfusion	10	15	31	26	16	21	39	21	29
Sharing of sharp object	16	33	19	25	23	40	40	12	27
Mother to Child	02	02	04	10	03	04	04	07	05
HIV Prevention: Abstaining from sex	24	34	23	29	21	39	39	21	29
Being faithful	06	08	17	14	10	15	26	08	13
Condom use	06	08	14	18	07	12	26	08	12
Not receiving unscreened blood	04	07	18	17	06	21	17	12	13
Using new razor/needles	19	28	06	15	20	29	18	13	19

Knowledge of means of transmission of HIV &AIDS was generally low among the children. Less than one-third (32%) of the children that were interviewed were able to mention without prompting sexual intercourse as a mean of contracting HIV. Only 29% mentioned blood transfusion, 27% sharing of sharp objects and 5% mentioned mother-to-child transmission as other major means of HIV transmission.

Knowledge of HIV prevention was also very low among the children. Less than a third (29%) of the children mentioned abstaining from sex as a way of preventing HIV, 19% mentioned that HIV could be prevented by using new razor/ needles and 13% identified being faithful to one sexual partner as a mean of HIV prevention. Another 13% of the children mentioned that HIV could be prevented by not receiving unscreened blood while 12% of the children mentioned condom use is a mean of preventing HIV. Knowledge of HIV transmission and prevention was highest among children in Kogi state and lowest among children in FCT. Low HIV knowledge rate in FCT could be as a result of constant relocation of families due to demolition exercises and a large number of transit populations in the territory.

10.2 Knowledge of HIV Transmission and Prevention by Residence, Sex and Age

The level of awareness of HIV and AIDS was higher among the urban children than rural and semi-urban children, higher among the older children than younger ones and slightly higher among boys than girls.

Table 26: Knowledge of HIV Transmission and Prevention by Residence, Sex and Age

	Residence				Sex			Age		
Awareness, Attitude & Knowledge	Urban (%)	Semi urban (%)	Rural (%)	X^2	Male (%)	Female (%)	X^2	6-12yrs (%)	13-17yrs (%)	X^2
Awareness & Attitude to HIV										
Heard of HIV & AIDS	73	64	65	.000	68	67	.822	55	81	.000
Willing to eat from same plate with a PLWA	33	34	16	.000	31	28	.409	23	38	.000
Willing to care for a relative who is a PLWA	49	57	61	.000	55	55	.688	45	67	.000
Knowledge of Transmission										
Sexual intercourse	30	33	33	.000	32	31	.470	20	45	.000
Blood transfusion	22	22	19	.237	21	21	.766	13	31	.000
Sharing of sharp object	32	25	22	.000	26	27	.574	19	35	.000
Mother to Child	07	03	05	.000	05	05	.803	03	06	.000
Prevention										
Abstaining from sex	28	29	29	.000	29	29	.620	19	40	.000
Being faithful	11	13	14	.000	13	13	.979	08	18	.000
Condom use	13	12	12	.002	12	12	.866	07	18	.000
Not receiving unscreened blood	15	13	08	.000	13	12	.249	09	17	.000
Using new razor/needles	25	16	15	.000	19	19	.671	14	25	.000

Table 26 shows that 73% of urban children have heard of HIV and AIDS, while 65% of rural children and 74% of semi-urban children were aware of the epidemic. The level of knowledge of HIV transmission and prevention among urban and rural children was mixed. However, on average, children in urban communities appeared to be more likely to know modes of HIV transmission and means of preventing the infection than children in rural and semi-urban communities. Knowledge of mother to child transmission (PMTC) of HIV was generally low among all the children. In terms of attitudes towards PLWAs, rural children were less likely to be willing to eat from the same plate with a PLWA but more likely to be willing to care for a relative who is a PLWA than urban and semi-urban children.

Although, there was no significant difference in the HIV knowledge, attitudes and practices among boys and girls, boys showed higher level of knowledge of HIV existence, transmission and prevention than girls. However, children aged 13-17 had significantly higher knowledge of HIV issues than younger children (aged 6-12).

10.3 Knowledge of HIV Transmission and Prevention by Vulnerability

Orphans were more likely to have heard about HIV epidemic and more likely to have positive attitudes toward PLWHAs than non-orphans. Among the orphans, single orphans were more likely to have heard of HIV and AIDS but, double orphans were more likely to accept and care for PLWHAs. Among other vulnerable children, those living with old frail guardians were more likely to have awareness of HIV and AIDS and more likely to have positive attitudes towards PLWHAs than other vulnerable children.

Table 27: Awareness of HIV & AIDS and Attitudes of the Children toward PLWHA by Vulnerability

Vulnerability	Heard of HIV & AIDS (%)	X^2	Willing to eat from same plate with a PLWA (%)	X^2	Willing to care for a relative who is a PLWA (%)	X^2
Non orphan	66	.047	27	.000	54	.379
Orphans:	70		35		57	
Double	68		39		60	
Single:	70	.000	33	.000	56	.000
Paternal	69		34		56	
Maternal	73		31		53	
Other Vulnerable children:						
Living with disability	62		35		53	
Living with chronically ill parent(s)	66	.000	28	.000	51	.000
Living with old frail guardian	70		36		44	
Living in HH an adult died recently	73		21		47	

The data showed that 70% of orphans and 66% of non-orphans had heard of HIV and AIDS, 35% of orphans and 27% of non-orphans would be willing to eat from the same plate with PLWHAs and, 57% of orphans and 54% of non-orphans would be willing to care for a relative who is a PLWHA. The data further showed that 70% of single and 68% of double orphans were aware of HIV epidemic but 39% of double and 33% of single orphans reported willingness to eat from the same plate with a PLWHA and 60% of double and 56% of single orphans would be willing to care for a relative who is a PLWHA.

Table 28: Knowledge of HIV Transmission by Vulnerability

Vulnerability	Sexual intercourse (%)	X^2	Blood transfusion (%)	X^2	Sharing of sharp object (%)	X^2	Mother to Child (%)	X^2
Non orphan	30	.002	21	.177	25	.079	05	.969
Orphans:	36		22		29		05	
Double	31		16		29		06	
Single:	38		25		30		04	
Paternal	39		27		29		05	
Maternal	34		18		31		02	
Other Vulnerable children:								
Living with disability	22		10		16		03	
Living with chronically ill parent(s)	28		24		22		02	
Living with old frail guardian	44		36		32		00	
Living in HH an adult died recently	37		16		21		08	

Table 29: Knowledge of HIV Prevention by Vulnerability

Vulnerability	Abstaining from sex (%)	X^2	Being faithful (%)	X^2	Condom use (%)	X^2	Not receiving unscreened blood (%)	X^2	Using new razor Needles (%)	X^2
Non orphan	27	.001	11	.005	11	.010	13	.021	19	.140
Orphans:	33		15		15		12		20	
Double	29		10		12		09		21	
Single:	35		17		16		13		19	
Paternal	36		18		15		14		20	
Maternal	30		13		17		11		18	
	18		07		09		09		09	
	27		11		18		11		12	
	32		24		32		36		08	
	37		05		11		11		11	
Other Vulnerable children:										
Living with disability	18		07		09		09		09	
Living with chronically ill parent(s)	27		11		18		11		12	
Living with old frail guardian	32		24		32		36		08	
Living in HH an adult died recently	37		05		11		11		11	

Tables 29 and 30 show that the knowledge of modes of HIV transmission and prevention was higher among orphans than non-orphans; higher among paternal orphans than maternal and; higher among children living with frail guardians than other vulnerable children.

10.4 Findings from Qualitative Data

Many of the orphans who participated in the FGD had heard of HIV & AIDS. A good percentage of them knew the mode of transmission, prevention signs and symptoms of HIV & AIDS. However, there were some misconceptions about HIV & AIDS amongst them. For example, some of them believed that HIV could be transmitted through sharing of plates, eating together, sharing sponge etc. When asked how they could protect themselves some rightly mentioned avoiding sharing of sharp objects like razor, abstinence, faithfulness for those who were married, and *"not going around"* or *"not moving badly"* in the words of some participants. A male participant said:

"if one should have sex at all, one should use condom to protect oneself from contracting HIV".

Many participants affirmed that if one exercised restraint one would not contract HIV. They also asserted that people who were promiscuous usually contracted the virus. Some of them did not have knowledge of condom usage, while those that had the knowledge did not know what purpose of its uses is.

On whether they knew of people living with HIV in their community, majority of them said they knew people in their communities who were living with the virus. However, few of them reported that they knew of persons who died of AIDS. They also provided some of the local names of HIV as follows:

The local names used to describe HIV & AIDS depict the people's knowledge, attitude and perception of the virus and the disease. For instance, the Hausa name 'Ciwon Zamani' which means 'modern sickness' is an indication that they acknowledged the fact that the HIV is a recent phenomenon. Other names such as 'Anakande' (Tiv) meaning 'sliming disease' described AIDS as a disease that makes the victims to loose weight and 'Aisan ti ko gboogun' (Yoruba) describing AIDS as an incurable disease. Some of the names also depict the people's beliefs about the cause of the virus. For example, 'Eedi' (Yoruba) which means a sickness that makes a person behave like someone who is bewitched.

Local Names for HIV and AIDS

Ciwon zamani *(Hausa)- Modern sickness*
Ciwon AIDS *– (Hausa)- Sickness of AIDS*
Women's Disease
Obinachocha *(Ibo) – Clean heart.*
Ciwon Kanjamau *(Hausa) -disease without medicine.*
Yarazamani *(Gbagyi)- Modern sickness*
Anakande *(Tiv) -Slim disease (a disease that makes one get slim)*
Akpugbe *(Igala) - Destroyer*
Aisan to ko Gbogun *(Yoruba) - Incurable disease*
Eedi *(Yoruba) - A sick that make a person behave like some that they cast spell on*
4 + 4- *AIDS sounds like the English numeral '8' and they do not want to call the word AIDS.*
8 - *AIDS sounds like the English numeral '8'*
Ujiagbe- *(Esan, Edo), 'Unkillable' Something that cannot be killed*
'Has Swallowed a leather' *(Daffor,Plateau)- Swallowed an indigestible material which leads to death.*

Most of the caregivers in the FGD said that HIV was real and the spread of the epidemic was increasing in their communities. They observed that the community members were aware of HIV & AIDS but the people lacked in-depth knowledge of disease. Most of the participants had not tested for HIV because they were afraid of being stigmatized. Some of the caregivers in the group reported that they usually discussed about HIV & AIDS and reproductive health issues among their peers. They reported that although they usually advised their children against sexual promiscuity, they hardly discussed sexuality and reproductive health issues with their children. The group also mentioned local names for HIV & AIDS most of which had been mentioned in the children group.

Many of the community leaders interviewed agreed that HIV & AIDS was on the increase in their communities. One of them said that with the advent of ART deaths from AIDS seemed to be reducing. Another community leader was of the opinion that ART was only being given to big people in government. Others said that people were still dying of AIDS because of non disclosure of their status. A traditional ruler in Kaduna state asserted that less people were currently dying of HIV & AIDS because of the awareness that was being created about it.

Another traditional ruler from an urban community in Kaduna state said that HIV & AIDS was a self inflicted disease that people contract by being promiscuous. He said if people listened, they would not contract the disease. He quoted a popular Hausa proverb:

> *"In kwiini ya ji, gangan jiki yai tsira".* Meaning *"If the ears hear, the main body will escape. It is only when the ears do not hear that the main body will fall victim"*

A community leader in Nasarawa State believed that the major problem in his community was malaria and not HIV & AIDS. He further explained that the medical personnel now confused HIV with malaria. He said that most people in the community had stopped going to the hospital for malaria treatment because each time a person went to the hospital for malaria treatment, the doctors would tell him/her to have contracted HIV.

Most of the community leaders interviewed reported that there were HIV & AIDS activities been conducted by different organizations in their communities but most people did not have thorough understanding of HIV & AIDS. Some of the community leaders requested from the field officers how they could get people to come and give HIV & AIDS education to their people in their communities especially the women and youth. Some of them also complained of limited access to VCT.

Some traditional rulers affirmed that they usually discussed HIV & AIDS with their people in their communities. The discussions usually centred around prevention, and urging children to abstain from sexual intercourse before marriage, stay faithful in marriage and avoid the use of unsterilized razor blades, needles for piercing tattoos/body art, and skin piercing objects. They said that women discussed HIV with their daughters, especially when they watched movies or listened to jingles and always advised them to "be careful". One of the youth leaders reported that some of the youths had reduced their sexual activities now because of these types of warnings they received. They also advised youths to go for HIV test before marriage.

Some of the leaders of youth organizations said that they discussed with youths in Islamic schools and give lectures, symposia and other activities to members of the community. Recently a youth organization in Kaduna state organized a symposium through the assistance of UNICEF and which was stepped down in the communities. They erected billboards with HIV and AIDS messages on major streets and conducted published health talks in the communities. Many community leaders also reported that most of the talks that were given to the young people in the communities were on HIV & AIDS and sexual relationships. When they were asked about discussion of other sexual and reproductive health matters, most of them said such discussions were not common in their community.

Most of the community leaders said they did not have organizations working in the area of OVC in their communities and there was a great need for this with increasing number of OVC in their communities. They also wanted help and support in the area of poverty alleviation.

10.5 Programmatic Implications of the Findings

The study showed very low level of awareness about HIV & AIDS pandemic among the children. The low knowledge of transmission and prevention of HIV among the children is also worrisome. Efforts to stop the spread of the scourge of HIV & AIDS in Nigeria cannot be achieved if the younger generation (children) were not informed about the epidemic. The

culture of silence about issues related to sex among the children has contributed to the low awareness and knowledge about HIV & AIDS among the children. Parents and guardians should be encouraged to break the culture of silence and discuss HIV and reproductive health related issues with their children/wards to reduce their vulnerability to HIV infection.

The results also confirmed the fact that most of the HIV & AIDS awareness campaign in the country has not been targeted to children. The information and the messages are in most cases too complex or coded in a way that younger children (below 12 years) may not understand. Children-friendly and children-focused age appropriate HIV campaign messages should be developed urgently and massive roll-out of the campaign should begin immediately to raise the level of awareness and knowledge of HIV & AIDS among the children to 100%.

SECTION ELEVEN: SEXUAL ACTIVITY AND RISKY BEHAVIOUR AMONG CHILDREN AGED 13-17 YEARS

11.0 Sexual Activity and Risky Behaviour of the Children Aged 13-17 by States

Table 30: Sexual Activity and Risky Behaviour of the Children Aged 13-17 by State

Sexual activity and Risky Practices	FCT N= 61 (%)	Benue N =185 (%)	Nassar N =121 (%)	Niger N =234 (%)	Kad N=402 (%)	Plateau N =158 (%)	Kogi N =128 (%)	Edo N =172 (%)	Total N =1461 (%)
Ever had a boy/girl friend	13	23	30	24	19	27	16	15	21
Ever had sexual intercourse	06	26	23	17	13	17	15	12	16
Ever used condom during sexual intercourse	23	21	14	24	16	17	10	10	15
Correct knowledge of the use(s) of condom	31	52	39	35	17	52	31	31	40
Correct knowledge of Abstinence	15	31	32	31	25	40	48	24	31
Practice Abstinence	19	46	22	25	43	52	31	21	32
Other Risky Practices: Ever smoked cigarettes/tobacco	04	02	01	01	01	0	0	0	01
Takes alcoholic drinks	09	33	06	02	02	04	0	08	08
Ever taken illicit/hard drug	0	30	0	06	02	0	02	05	03

Issues about sexual activity and risky behaviours were discussed with children who were between 13 and 17 years of age only. This group (13-17 years) constituted 48% of all children interviewed with structured questionnaire. Findings of the study revealed that 21% of the children aged 13 – 17 years had romantic boy/girl friends while 16% of them report that they had ever had sexual intercourse. Children in Benue state were the most sexually active with more than one-quarter (26%) of children aged 13-17 years in the state have had sexual debut. The least percentage (6%) of sexually active children was from FCT. Of the 16% who were sexually experienced, 15% had ever used condom. Two-fifth (40%) of the children had correct knowledge of the use(s) of condom. More than a half of the children (52%) in Benue and Plateau states were able to mention that condom is used to prevent pregnancy and sexually transmitted infections, including HIV. The least knowledge rate (17%) about condom use was among the children from Kaduna state.

When children aged 13-17 were asked to define "Abstinence", less than one-third (31%) of the children were able to correctly state that abstinence is "a deliberate/conscious attempt to avoid having sex" and about the same percentage (32%) claimed that they practiced abstinence. Kogi state had the highest percentage (48%) of children with the correct knowledge of abstinence while the highest percentage (52%) of the children practicing abstinence was from Plateau state. FCT had the least percentage (19%) of children practicing abstinence.

Assessing the involvement of the children aged 13-17 in risky practices/behaviour such as cigarette and tobacco smoking, drinking of alcohol and illicit/hard drugs, the study revealed

that 8% of the children were taking alcoholic drinks, 3% had ever taken any illicit/hard drugs while a negligible percentage (1%) engaged in cigarette smoking. Drinking of alcohol and illicit/hard drugs were more rampant in Benue state than any other state.

11.2 Sexual Activity and Risky Behaviour of the Children Aged 13-17 by Residence and Sex

The results showed that children in the rural communities were more sexually active than children in urban and semi-urban communities while more girls were sexually active than boys.

Table 31: Sexual Activity and Risky Behaviour of the Children Aged 13-17 by Residence and Sex

	Residence				Sex		
Practices	Urban (%)	Semi urban (%)	Rural (%)	X^2	Male (%)	Female (%)	X^2
Ever had boy/girl friend	18	21	25	.000	19	23	.164
Ever had sexual intercourse	11	17	20	.002	13	18	.152
Ever used condom	11	15	18	.000	13	17	.128
Have correct knowledge of condom use	34	38	28	.053	34	33	.716
Know what Abstinence means	23	39	32	.000	31	31	.722
Practice Abstinence	32	28	42	.000	33	32	.816
Ever smoked	01	01	01	.799	01	0	.126
Drinks alcoholic drink	07	11	05	.000	08	07	.170
Ever taken illicit drug	04	02	02	.028	03	02	.228

Among the rural children, a quarter had ever had boy/girl friends and a fifth (20%) have had sexual debut. This is in contrast to 18% and 21% of children in urban and semi-urban (respectively) who had ever had boy/girl friends and 11% of urban children and 17% of semi-urban children who had ever had sexual intercourse. Data on condom used showed that 18% (out of 20% sexually active) of the rural children had ever used condom, 15% (out of 17% who were sexually active) of semi urban children had ever used condom while all sexually active children in urban areas (11%) had ever used condom. Rural children were less likely to have adequate knowledge of what condom is used for than urban and semi-urban children. However, urban and semi-urban children were more likely to engage in risky behaviours than rural children. For example, while 11% of semi-urban and 7% of urban children drank alcohol, only 5% of the rural children engaged in the act.

The data only showed that girls were more likely to have had romantic boy friends and more likely to have had sexual intercourse than boys. However, there were no significant differences in the knowledge of the use of condom, correct understanding of the meaning of abstinence and risky practice among boys and girls.

11.3 Sexual Activity and Risky Behaviour of the Children Aged 13-17 by Vulnerability

Table 32: Sexual Activity and Risky Behaviour of the Children Aged 13-17 by vulnerability

Vulnerability	Ever had boy/girl friend (%)	Ever had sexual intercourse (%)	Ever used condom (%)	Have correct knowledge of condom use (%)	Know what abstinence means (%)	Practice Abstinence (%)	Ever smoked (%)	Drinks alcoholic drink (%)	Ever taken illicit drug (%)
Non orphan	19	12	12	38	31	42	01	07	04
Orphans:									
Double	25	22	15	34	35	52	01	07	02
Single:	23	22	14	31	32	30	00	08	02
Paternal	21	19	12	31	35	31	00	07	02
Maternal	26	31	18	31	27	30	00	09	01
Other Vulnerable children:									
Living with disability	22	29	29	33	28	29	01	07	00
Living with chronically ill parent(s)	20	14	05	26	19	31	00	04	00
Living with old frail guardian	33	44	33	36	25	27	00	10	00
Living in HH an adult died recently	38	27	20	32	41	39	00	10	05

The orphans were more likely to have engaged in sexual activity and less likely to have adequate knowledge of sexual and reproductive issues than non-orphans. The data further showed that double orphans and maternal orphans were more likely to have ever had boy/girl friend than single and paternal orphans respectively while, maternal orphans were more likely to have had sexual intercourse than other types of orphans. Among other vulnerable children, those who were living with old frail grand parent or guardian were more likely to have had sexual intercourse than others.

11.4 Programmatic Implication of the Findings

The result showed that significant proportion of the children was already sexually active and many of the sexually active children engaged in risky (unprotected) sexual practices. Denial and culture of silence on sexual matters, especially among the children, has prevented many interventions aimed at reaching the children with reproductive health information. Intervention to educate children on age appropriate sexual and reproductive health issues which focus on abstinence and delay of sexual debut, assertive skills, and life skills would promote behaviour change and reduce risk of HIV infection among young people. Such intervention can be school based and can be mainstreamed into the school curriculum, similar to the Life Planning Education being implemented in south western part of the country.

SECTION TWELVE: PROBLEMS CONFRONTING THE CHILDREN

12.1 Problems Confronting the Children by State

Table 33: Problems Confronting the Children by State

Problems	FCT N=161 %	Benue N=437 %	Nassar N=279 %	Niger N=530 %	Kad N=674 %	Plateau N=337 %	Kogi N=322 %	Edo N=345 %	Total N=3086 %
Lack of money for school fees	32	39	24	28	49	51	34	35	38
Insufficient food	10	14	42	22	10	21	26	27	20
Poor health	04	03	20	13	06	10	09	06	09
Too much household chores	07	08	03	05	02	10	06	05	05

Findings on the problems being experienced by the children revealed that lack of money for school fees was the greatest challenge. More than one-third (38%) of the children reported that they had problems in paying their school fees. Lack of money for school fees affected more than a half (51%) of the children in Plateau state while the least reported case of lack of money for school fee was in Nassarawa (24%).

The second most important problem reported by the children was insufficient food. One-fifth (20%) of the children reported that they were faced with problem of insufficient food. Children in Nassarawa state reported cases of food insufficiency as 42% of them did not always have enough food to eat. Children in FCT and Kaduna state reported the lowest percentage (10%) of insufficient food.

Poor health and too many household chores were ranked the least among the problems confronting the children, with only 9% and 5% (respectively) of the children reporting them as problems. Poor health status was mostly reported by the children in Nassarawa (20%) and least reported in Benue state (3%). On having to do too many household chores; the highest percentage of children reporting it as a problem were from Plateau (10%) while and children from Kaduna state reported the least percentage (2%).

12.2 Discussions and Programmatic Implications of the Findings

Although the majority of the children reported been sick in the last 3 months and less than a third rated their health status as “very good”, most children did not consider their poor health as a major problem. Health was rated the least of the problems confronting the children. This may be due to the fact that most children do not considered common causes of sickness, especially malaria, as a major health concern and it may also reflect the poor attitude to health. The children might have rated education and nutrition ahead of health because health is an occasional event unlike education and nutrition, which are daily phenomenon. Health intervention program should focus on health awareness creation and promotion of good health seeking behaviour among the children and their caregivers.

Street Children's Perspective

During the focus group discussion with a group of male street children in Benin City Edo state, the children revealed that the street children were popularly called "Lay men" and "Ogbela" meaning somebody without parents who eats remnants on the street.

Reasons for Being on the Street

Most of the children reported that they were on the street because nobody cared whether they went home or not, some of them complained about maltreatment they received from their step parents, while others were on the street to work for money for the upkeep of their family members, especially surviving sick parents. The street children agreed that living on the street was on the increase.

Problems

Majority of the discussants reported that they hardly received care from anyone. There were stigmatized as thieves by the community members; constantly harassed by older peers and always chased away by security men at nights to prevent them from sleeping around people's homes. Most of the street children were introduced to sexual activities and were coerced to engage in homosexuality with their older peers. The children identified other major problems they faced to include: lack of money for feeding; lack of good clothes and; emotional problems arising from a desire to see their parents. Some of the children faced problems of hunger and inadequate food; poor health condition; incessant police arrest and lack of accommodation.

Some of the children reported that they usually helped people to do household chores in exchange for food while the younger ones complained that they were sometimes not offered work because they were too young or too dirty. Some of the children expressed desire for a good and peaceful family life. A 14 year old boy expressed desire to go back to his mother while others would only go home if their step parents were no longer in the home. The children reported that they usually discussed their problems with their peers, older street boys and the bus conductors among them discussed their problems with their masters. Those of them that lived around religious premises said they discussed their problems with the religious leaders.

Changes Experienced

When the children were asked about what have changed in their conditions since they started living on the street, most of them listed the following: worse sleeping place, less food and clothes, less access to health care and less access to sanitary facilities. Almost all of them were no longer attending schools. The general consensus was that they suffered more on the street than when they were living in households.

On the other hand, the street children added that they had access to more money as street children than when they were with their parents. They also reported to have more freedom to do what they like, they could eat whatever they wanted especially when they had money and, they made more friends.

Relationship with Peers

Most of the street children reported to have good social relationship with their peers, while others reported that they frequently had conflicts with older peers arising from quarrel over food, meat, sexual coercion and harassment. They also reported that they were often abused emotionally and physically by the people in the community.

Knowledge of HIV & AIDS

Majority of the children in FGD had heard of HIV & AIDS. Some of the local names given to HIV and AIDS by the street children includes: ORIGINAL CRAW CRAW (original rashes); Ujiagbe (unlikeable) and; Quick sick (a sickness that one gets easily).

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Focus Group Discussion with Almajiri Children

Background

Almajiri is a form of Islamic education whereby young boys ages 5 - 17 years old acquire Islamic knowledge under a tutor/Quranic teacher. Large cities throughout the Northern Nigeria serve as centres for this form of education. Children from rural communities are brought to Quranic establishments in the cities for duration of between 3- 10 years. Within this period, they are able to master and recite the Holy Quran and no western/modern education is included in the curriculum. The parents/wards are responsible for identifying and bringing these children to the establishments. Many of the children on completing their education identify a business or skill which they intend to pursue after their education. Hence they rarely go back to their communities but stay on to become successful or otherwise. The tutor/teacher accommodates 20 - 100 young children for the duration of the training during which he is responsible for their up keep (feeding e.t.c). However, the teacher is often incapable of feeding or providing for them adequately.

Characteristics

Many of the children reported that they became Almajiri as part of the religious obligation. Almajiri was regarded as training for independence under an Islamic scholar for a period 3 to 10 years. During the period of training, the parents of the Almajiri paid them visits from time to time to assess their welfare.

Problems

Almost all of the Almajiri children complained of insufficient food as a major problem. They had to go on the street to beg for food and alms in the morning and evening while they attended Quranic lesson in the afternoon. Most of the children did not have good clothes and they usually slept under leaked roofs or open places on bare floor; thereby exposed to harsh weather condition, especially rain. They were frequently harassed by the security officers and community members accused of stealing. The children also complained of limited access to health care when they fell sick. They relied on philanthropic persons to provide money for their medical treatments.

Relationship with Peers

The Almajiri children considered conflicts among peers as inevitable, but they tried to resolve their differences as soon as possible. The major causes of conflicts were: food, money, sleeping spaces and harassment by older ones.

Awareness about HIV & AIDS

Awareness about HIV & AIDS was low among the Almagiri. While some reported that were aware of the epidemic, many others claimed that they had not heard about HIV & AIDS. The common name for HIV & AIDS among the Alimajiri was “Ciwon zamani” meaning modern sickness. Knowledge of HIV prevention was also very low among the children. The older children among the Almajiri admitted having girlfriends.

SECTION THIRTEEN: CONCLUSION

13.1 Recommendations

Recommendations are made below in order to resolve some of the programmatic and policy issues raised by the findings of the study:

Demographic Characteristics (Shelter and Care)

- Intervention to strengthen the traditional safety net of the extended family structure should be encouraged. The capacity of the family to adequately care for the orphans should be strengthened. This may include poverty alleviation and economic/livelihood development interventions.
- Household based intervention for orphans (e.g nutrition supplement/food supplies) should include other children in the household in the planning
- Household Economic strengthening intervention that targets the surviving mothers and guardians may be one of the ways to reduce incidences of child labour. Older orphans (ages 15 and above) may also be trained on income generating skills/vocation to reduce the tendency of engaging in high risk and dangerous activities.
- The variation in prevalence of OVC across community should be considered in program planning and resource allocation. It is also pertinent that OVC intervention programs should involve collaboration with other interventions that aimed at reducing the causes of death of parents in the communities.
- Gender and age variations in the need of OVC should be considered in planning for package of services to be provided for OVC of different sexes and ages.

Education

- Education interventions for orphans should not only concentrate on orphans that are currently in school but, should also re-enroll those who dropped out of school after the death of their parents.
- In case there is need to prioritize interventions (due to resources constraints), education program should come first in response to the expressed need of both the children and caregivers.
- It is important that access to Universal Basic Education and skills acquisition programs be made available to Alimajiris, street children, and others children outside of the formal education system.

Health

- Health intervention programs should focus on malaria prevention (such as provision of mosquitoes treated nets, malaria prophylaxis etc) and other major causes of sickness among the children in collaboration with patent medicine distributors. Programs to strengthen primary health care system to adequately deal with malaria should also be encouraged.
- Health intervention programs should focus on health awareness creation and promotion of good health seeking behaviour among the children and their caregivers.
- Despite the fact that health issues were not amongst the major concerns reported by the OVC, health intervention should still form part of the package of services being provided for OVC since poor health is the major predictor of child mortality.

Food intake & Nutrition

- Since food intake is a joint (household) decision, nutrition intervention should focus on all children irrespective of their orphan status.

Psychosocial Support

- Capacity building on psychosocial support for OVC for guardians and programmers is highly recommended. This is to provide stress reduction for caregivers through economic support and community building (support groups with income generating activities, or support groups assisting in child care within the communities) thereby enabling them to respond to the emotional needs of OVC and other children in difficult circumstances.

Abuse, Rights and Protection

- The issues of low birth registration and birth certificate require intervention such as childbirth registration campaign among parents and guardians.
- There is a need for awareness campaign on the importance of will writing and Succession Planning, especially among community and religious leaders and persons with chronic diseases such as those living with HIV

HIV & AIDS

- Parents and guardians should be encouraged to break the culture of silence and discuss HIV and reproductive health related issues with their children/wards to reduce their vulnerability to HIV infection.
- Children-friendly and children-focused HIV campaign messages should be developed to raise the level of awareness and knowledge of HIV/AIDS among the children to age appropriate levels.
- Program of intervention to educate children on sexual and reproductive health issues focusing on abstinence, assertive skills, and empowerment should be developed. Such intervention should be school based and should be mainstreamed into the school curriculum.

Monitoring and Evaluation

- Effective monitoring and evaluation mechanism should be put in place to measure the effectiveness of the existing OVC interventions at all levels.

13.2 References

Ainsworth, M; Beegle, K and; Koda, G "The Impact of Adult Morality on Primary School Enrolment in Northwest Tanzania", World Bank, Development Economics Research Department, Washington DC, 2000

Federal Ministry of Women Affairs and Social Development, "National Guidelines and Standards of Practice on Orphans and Vulnerable Children", Abuja, January, 2007.

National Population Commission (Nigeria) "Nigeria Demographic and Health Survey 1999", Calverton, Maryland: National Population Commission and ORC/Macro, December, 2000.

Nyangara, F "Sub-National Distribution and situation of orphans: An analysis of the President's Emergency plans for AIDS Relief Focus Countries", Washington, DC: Population, Health and Nutrition Information project/USAID , 2004.

Subbarao, K; Mattimore, A and; Plangermann, K "Social protection of Africa's orphans and other vulnerable children: Issues & good practices", The World Bank, 2001.

UNICEF "Africa's Orphaned and Vulnerable Generations: Children Affected by AIDS", The United Nations Children's Fund, New York, August, 2006.

UNICEF, Multiple Indicator Cluster Survey Manual. 2004

SECTION FOURTEEN: APPENDIX

14.1 Field Work Team Members

FCT Team

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Kogi State Team
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Sylvanus Okpanachi- Supervisor
Japhet Omaye- Supervisor
Niyi Olaleye- Coordinator

Plateau State Team
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Patricia Suawam- Supervisor
Jummai Almadu- Supervisor
Ochi Ibe- Supervisor
Sr Jovita Egwu- Supervisor

14.2 List of Communities surveyed

S/N	State	LGA	Communities	Locality
1	Edo	Eghor Esan West Ovia North East	Okhoro, Benin city Eguare, Ekpoma Egbeta	Urban Semi-urban Rural
2.	Niger	Chanchaga Bida	Chanchaga, Bida Bida Gawu-Babangida	Urban Semi-Urban Rural
3.	FCT	AMAC Abaji Kuje	Asokoro, Abuja Abaji Pegi	Urban Semi-Urban Rural
4	Lafia	Lafia Nasarawa Obi	Lafia Nassarawa Obi	Urban Semi-urban Rural
5	Benue	Makurdi	High Level, Makurdi	Urban
		Ogbadibo	Otukpa	Semi Urban
		Guma	Udei	Rural
6	Kaduna	Kaduna	Anqwan Kanawa, Kaduna	Urban
		Zangon Kataf	Zonkwa	Semi Urban
		Kuche Makaranta	Kuche makaranta	Rural
7	Kogi	Lokoja	Lokoja	Urban
		Idah	Idah	Semi Urban
		Ejule	Ejule	Rural
8	Plateau	Jos South	Bukuru, Jos	Urban
		Daffo	Daffo	Rural
		Kurgwi	Kurgwi	Semi-urban

14.3 Survey Instruments

14.3.1 Questionnaire for Children 6-17 Years of Age

Serial ☐☐☐☐ **number**

State_____ Diocese _____

Local Government Area _____ Parish _____

Name of Community _____
Date: _____ Start Time: _____

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Hello! I am _____ and my partner is _____. We are here on behalf of the ……. We're talking with adults and children ages 6 to 17 to get information about their lives and how they have been coping, especially in difficult times. We have already been talking to your parent/guardian on the same issue and now we would like to try to understand what you think. Have you been interviewed in the past two weeks for any research on children or some other issues? (***If they have been interviewed for purpose of this same study, thank them and end interview).***

We would like to ask you some questions. Some of these questions talk about things that you might find quite personal, or may be difficult to answer. If any of the questions make you feel uncomfortable or if you don't want to answer them, you do not have to. However, we would really appreciate it if you would answer the questions honestly and openly, so that we can find out what young people here in (name of community) really think. Your answers will be very important to us. Do you have any questions about any of the things I have just said? (If any questions are asked, clarify; if not, proceed).

Consent Form

We'll be asking children from different parts of Nigeria the same questions. When the survey is finished, we will collect all the responses we have received in **(n*ame of community)*** and keep them safe. Someone in our Office will add them together. The results will be available through the local diocese. If you agree to take part in this interview, the things you tell me will be confidential. That means they will be private between you and me. I am not going to write down your name or talk to other people about what you tell me. Do you have any questions about any of the things I have just said? (if any questions are asked, clarify, if not proceed

Are you willing to participate in the survey? Yes ☐ No ☐

Is there someone you would like to stay with us while talking? Yes ☐ No ☐

WHO: _____

Signature of Interviewer _____ Date _____
(Certifying that informed consent has been given verbally by respondent)

(Optional)
ignature of Caregiver _____ Date _____
(I choose to give signed consent)

S/N	Questions and Filters		Coding Categories
1.1	**1.0 SOCIODEMOGRAPHIC CHARACTERISTICS** How old were you at last birthday?	 88 99	_____ years Don't Know No response
1.2	Sex of the respondent	1 2	Male Female
1.3	What is your religion?	1 2 3 4 5 6 88 99	Islam Christianity: Catholic Protestant Pentecostal Other Christian (Specify) _____ Other religion (specify):_____ Don't know No response
1.4	What is your ethnic group?		Specify: _____
1.5	What language(s) do you speak most of the time?		Specify:_____
1.6	Do you have a disability ***(if no, skip to 2.1)***	1 2	Yes No
1.7	Describe your disability.	1 2 3 4 5 77 99	Sight impairment Speech impairment Hearing and speech impairment Physical disability Learning disability Other specify _____ No response
2.1	**2.0 EDUCATION** Are you currently in school? ***(If yes, skip to Q 2.10)***	 1 2 99	 Yes No No response
2.2	***FOR CHILDREN NOT CURRENTLY IN SCHOOL*** Were you ever in school? ***(If No, skip to Q2.5)***	 1 2 99	 Yes No No response
2.3	Why did you stop going to school? ***(Do NOT prompt. Circle as many as child mentions)***	1 2 3 4 5 6 7 8 9 10 88 99	Death of parent(s) Death of guardian(s) Financial problems Illness /poor health of parent(s) Disability Self illness/poor health To assist /support family Poor performance (drop out) To work in own business Don't like school Don't Know No Response
2.4	At what class did you stop?		Specify: _____

2.5	Why were you never in school? ***(Circle as many as applicable)***	1 2 3 4 5 6 7 77 88 99	Death of parent(s) Death of guardian(s) Parents sickness Parent/Guardian Poor Disability Self illness/poor health No school in the community Others(specify)_____ Don't Know No Response
2.6	Given the opportunity now, would you want to resume school? ***(If no, skip to Q2.8)***	1 2 88 99	Yes No Don't know No response
2.7	What type of education would you like to have?	1 2 3 77 88 99	Formal education Non Formal educational Vocational Education Other (specify)_____ Don't know No response
2.8	Give reasons why you would not want to go to school ***(Do NOT prompt. Circle as many as child mentions)*** ***(If it is code 2 continue, otherwise skip to Q2.14)***	1 2 3 4 77 88 99	Too old Wish to learn trade Currently learning a trade Does not have access to disability friendly Others (specify):_____ Don't Know No Response
2.9	What type of trade/vocation would you like to learn? ***(Go to 2.17)***		Specify: _____
2.10	***FOR CHILDREN CURRENTLY ATTENDING SCHOOL*** What school do you go to?	1 2 3 4 5 77 88 99	Government owned school. Private owned school. Schools owned by Religious Organisations Community school Don't Know Others (specify):_____ Don't know No response
2.11	What class are you?		Specify_____
2.12	In the last examination, what was your Position Average score		Specify_____ Specify_____
2.13	In the last 4 weeks, how many days did you miss school?		Specify number of days:_____
2.14	Have you ever had to miss school for one or more terms? ***(if no SKIP to 2.16)***	1 2 99	Yes No No response
2.15	If Yes, specify	1 2 3 4	Parent's illness Death of parent/guardian Lack of school fees School too far from home

		77 88 99	Other (specify) _____ Don't know No response
2.16	How often do you attend school in a week?	1 2 3 4 5 6 88 99	Every day 4 days a week 3 days a week 2 days a week 1 day a week Do not attend school Don't Know No response
2.17	What are the things you normally do before going to school? ***(Do not prompt)***		Specify: _____ _____
2.18	What are the things you normally do after returning from school ***(Do not prompt)*** ***(Do NOT prompt. Circle as many as child mentions)***	1 2 3 4 5 6 7 8 77 99	Play Homework Watch television Sleep Cook Fetch water/firewood Trading Other household chores Others (specify)_____ No Response
2.19	***FOR All CHILDREN*** Have you ever worked for money/engaged in any economic activity? ***(If no, skip to Section 3.0)***	 1 2 99	 Yes No No response
2.20	Have you ever worked to get food or any other gifts instead of money?	1 2 99	Yes No No response
2.21	What types of work do you do? ***(Circle all that are applicable)***	1 2 3 4 5 6 77 99	Fetch water Hawk goods Labour work (on farms, construction sites, workshops, plantations, begging etc) Wash clothes Motor conductor/ Motor bike rider Head loading/goods carrying Others (Specify)_____ No response
2.22	What is the MAIN reason why you work? ***(Circle the most applicable only)***	1 2 3 4 5 77 88 99	To supplement family income To support younger ones To pay school fees/support self To pay family debt To help in family business Other (specify):_____ Don't Know No Response
3.1	**3.0 SHELTER AND CARE** How many children (<18years) including yourself are living with you in this household?	- - 88 99	Total _____ (indicate number) Boys_____(indicate number) Girls_____(indicate number) Don't Know No Response
3.2	How many of these children have the same parents as you?	- - - 88	Total _____ (indicate number) Boys_____(indicate number) Girls_____(indicate number) Don't Know

		99	No Response
3.3	How many of you are sleeping in the same room?	- - - 88 99	Total _____ (indicate number) Boys_____(indicate number) Girls_____(indicate number) Don't Know No Response
3.4	How many rooms are there in this household for sleeping?	___	Specify_____(number)
3.5	How long have you been living here?	1 2 3 4 5 88 99	Since birth More than 24 months Between 12 and 24 months Between 6 to 12 months Less than 6 months Don't know No response
3.6	What do you sleep on?	1 2 3 4 77 99	Mat Bed Bare floor Chair Others (specify) No response
3.7	Are you comfortable (okay) living in this house	1 2 88 99	Yes No Don't Know No Response
3.8	***Observe and record (through question 3.10)*** Type of the house/dwelling	1 2 3 4 5 77	Thatched hut Room(s) Flat Duplex Whole building Others (specify):_____
3.9	Material of roof of the house	1 2 3 4 77	Zinc Thatched hut Asbestos Aluminium Others specify)_____
3.10	Material of the floor of the dwelling	1 2 3 77	Tile Concrete Bare floor without concrete Others (specify)_____
3.11	What is the **MAIN** source of drinking water for members of this household?	1 2 3 4 5 77 88 99	Pipe in dwelling Hand pump/borehole nearby Dug well in the compound Tanker/vendor River/Stream Others (specify)_____ Don't Know No Response
3.12	Who fetches the water for household use MOST of the time? ***(Circle the most applicable only)***	1 2 3 4 5 6 7 8 9 10 11	Myself Mother of household Grandmother of household Other adult females of household Father of household Grandfather of household Other adult males of household Female child (biological child) Female child (non-biological) Male child (biological child) Male child (non-biological)

		12 88 99	Maid/Worker Don't Know No Response
3.13	What kind of toilet do you use	1 2 3 77 99	Flush/water system Pit latrine Bush Other (specify)_____ No response
3.14	Who cleans the toilet MOST of the time? ***(Circle the most applicable only)***	1 2 3 4 5 6 7 8 9 10 11 12 88 99	Myself Mother of household Grandmother of household Other adult female of household Father of household Grandfather of household Other adult males of household Female child (biological child) Female child (non-biological) Male child (biological child) Male child (non-biological) Maid/Worker Don't Know No Response
3.15	What type of refuse disposal system do you use in this household?	1 2 3 77 88 99	Bin collected by agents Disposal pit within the compound Refuse dump Other(s) specify Don't Know No Response
3.16	Who disposes the refuse **MOST** of the time? ***(Circle the most applicable only)***	1 2 3 4 5 6 7 8 9 10 11 12 88 99	Mother of household Grandmother of household Other adult female of household Father of household Grandfather of household Other adult males of household Female child (biological child) Female child (non-biological) Male child (biological child) Male child (non-biological) Maid Worker Don't Know No Response
3.17	Which of these conditions apply to you? ***(read all options to respondent)*** ***(Circle all that are applicable)***	1 2 3 4 5 6 7 88 **99**	I have lost one of my parents I have lost my two parents My parent(s) is/are chronically ill A chronically ill adult died in this household recently I am living with old frail grand parent or guardian None of the above Don't Know No Response

3.18	How are you related to the person you are living with? ***(If it is code 1, skip to Q3.30, otherwise continue)***	1 2 3 4 5 6 7 8 9 88 99	Mother and father Mother only Father only Step mother/father Aunt/uncle Grandmother/Grandfather Sister/Brother Cousin/other relations No blood relationship Don't Know No Response
3.19	***FOR CHILDREN LIVING WITH PERSONS OTHER THAN PARENTS*** Who made the decision for you to move to this household?	1 2 3 4 5 77 88 99	Surviving parent Aunty/Uncle Grand mother/father Others relatives Myself Others (specify)_____ Don't Know No Response
3.20	Were you consulted?	1 2 88 99	Yes No Don't Know No Response
3.21	In comparison to your guardian's/caretakers children, how would you say you are treated?	1 2 3 88 99	Better Same Worse Don't Know No Response
3.22	Why are you not living with your parent(s)? ***(If it is code 1, continue, otherwise skip to Q3.30)***	1 2 3 4 5 6 77 88 99	Parent(s) Dead Parent(s) very sick Parents jobless/very poor Educational purposes Disability Parents divorced or not living together Other (specify)_____ Don't Know No Response
3.23	***<u>FOR ORPHANS ONLY</u>*** Which of your parents is/are dead?	1 2 3 88 99	Both father and mother Father only Mother only Don't know No Response
3.24	How long ago did you lose your parent/s?	1 2 3 4 5 88 99	Before birth More than 24 months Between 12 and 24 months Between 6 to 12 months Less than 6 months Don't Know No Response
3.25	Did your parent(s) make any plans for you or write a WILL before they died? ***(If no, skip to Q 3.27)***	1 2 88 99	Yes No Don't Know No Response
3.26	Was the WILL adhered to?	1 2 88 99	Yes No Don't Know No Response

3.27	What do you think was the cause of his/her death? (***Probe a little without being coercive. Do not accept "DON'T KNOW" right away and circle as many as applicable***.)	1 2 3 4 5 6 7 8 9 77 88 99	TB Malaria Cancer HIV/AIDS Spiritual illness Pneumonia Accident Diarrhoea Typhoid Other (Specify):_____ Don't Know No Response
3.28	What has changed in your life (circumstances, etc) since your parent(s) died? ***(Do NOT prompt. Circle as many as child mentions)***	1 2 3 4 5 6 7 8 77 88 99	My school attendance has dropped or stopped My grade has worsened I have to do more chores I have to take care of younger ones I have less food I have less clothes I have less access to health care services I have less access to recreational activities Other (specify)_____ Don't Know No Response
3.29	How do you think people in the community look at you?	1 2 3 4 77 88 99	Sympathetic Stigmatised Discriminated against The same as other children Other(specify)_____ Don't Know No Response
3.30	***FOR ALL CHILDREN*** Young people are often affected by some problems: Which of the listed conditions affect you **MOST**?	1 2 3 4 5 77 88 99	Insufficient food Lack of money to pay school fees Poor health Poor living conditions Too much of chores (i.e. household works) Other (specify)_____ Don't Know No Response
3.31	Who is the **first** person you talk to when you have a problem?	1 2 3 4 5 6 7 8 77 88 99	Parents (Father/Mother) Guardian Step mother/father Grand mother/father Blood brother/sister Foster brother/sister Friends No one/Keep to myself Other (specify)_____ Don't Know No Response
3.32	In case you are in need of something, from who do you normally request?	1 2 3 4 5 6 7 8 77 88 99	Parents (Father/Mother) Guardian Step mother/father Grandmother/Grandfather Sister/Brother Aunt/Uncle Cousin/ other relation Non relative Other (specify)_____ Don't Know No Response

3.33	With whom do you spend **MOST** of your free time?	1 2 3 4 5 6 7 8 77 88 99	Parents (Father/Mother) Guardian Caregiver/maid Grand mother/father Blood brother/sister Foster brother/sister Friends No one/Keep to myself Other(specify)_____ Don't Know No Response
	4.0 FOOD INTAKE & NUTRITION		
4.1	How many meals do you usually take per day?		No of times_____ (specify)
4.2	What did you eat yesterday?	1 2 3 4 99	Morning:_____ Afternoon:_____ Evening:_____ Did not eat No Response
4.3	Other than water what did you drink yesterday?	1 2 99	List:_____ _____ _____ Nothing else No Response
4.4	Are those the things you eat/drink usually?	1 2 99	Yes No No response
4.5	(If no) How different?	1 2 3 4 5 99	There was a party/celebration yesterday Something bad happened to me yesterday I was fasting yesterday I visited somebody yesterday Other (Specify) No Response
4.6	When was the last time you ate meat/fish/egg?	1 2 3 4 5 88 99	Today Yesterday Less than a week Last week Cannot remember Don't Know No Response
4.7	How often do you take meat/fish/egg with your meal	1 2 3 4 5 88 99	Regularly/Every day 3-5 times a week 1-2 times a week Less than once a week Does not eat meat/fish/egg Don't Know No Response
4.8	How often do other members of your family take meat/fish/egg along with their meal?	1 2 3 4 5 88 99	Regularly/Every day 3-5 times a week 1-2 times a week Less than once a week Does not eat meat/fish/egg Don't Know No Response
4.9	When last did you eat/drink a fruit? ***(Give examples of fruits)***		No of day_____
4.10	How often do you eat food to your satisfaction?	1	Always

		2	Sometimes/Occasionally
		3	Never
		88	Don't Know
		99	No Response
5.1	**5.0 HEALTH CARE** How many times have you been ill in the last 3 months?		Specify no of times_____
		88	Don't Know
		99	No Response
5.2	When was the last time you fell sick?	1	This week
		2	Between 1-2 weeks
		3	Between 2-3 weeks
		4	Between 3-4 weeks
		5	Over 4 weeks ago
		88	Don't Know
		99	No Response
5.3	What was the cause of your last episode of sickness?	1	Malaria
		2	Diarrhoea
		3	Cold/catarrh
		77	Others (specify)_____
		88	Don't Know
		99	No Response
5.4	Where did you go for treatment?	1	Treated by guardian /parents
		2	Patent medicine shop
		3	Traditional healer
		4	Primary health care clinic/CHEW
		5	General Hospital
		6	Private hospital
		7	Spiritual homes
		8	No treatment
		77	Other(specify)_____
		88	Don't Know
		99	No Response
5.5	Who paid for the treatment?	1	Parents (Father/Mother)
		2	Guardian/Caregiver
		3	Grandmother/father
		4	Self
		5	Relative
		6	Church/mosque
		7	Treatment was free
		77	Other(specify) _____
		88	Don't Know
		99	No Response
5.6	Generally, how will you rate your health status?	1	Very good
		2	Good
		3	Poor
		4	Very poor
		88	Don't Know
		99	No Response
6.1	**6.0 PSYCHOSOCIAL/EMOTIONAL WELLBEING** In the last 2 weeks, did you have scary dreams or nightmares?	1	Yes
		2	No
		88	Don't know
		99	No Response
6.2	How often would you say you have scary dreams or nightmares?	1	Often
		2	Sometimes
		3	Never
		88	Don't Know
		99	No response
6.3	How often would you say you feel sad?	1	Often
		2	Sometimes

		3 88 99	Never Don't Know No response
6.4	How often do you feel happy?	1 2 3 88 99	Often Sometimes Never Don't Know No response
6.5	In the last two weeks, how many times did you fight with other children?	 88 99	Specify _____ Don't Know No Response
6.6	How often would you say that you ever get into fights with other children?	1 2 3 88 99	Often Sometimes Never Don't Know No Response
6.7	How often would you say you prefer to be alone instead of playing with other children?	1 2 3 88 99	Often Sometimes Never Don't Know No Response
6.8	How often would you say you ever felt worried?	1 2 3 88 99	Often Sometimes Never Don't Know No Response
6.9	How often would you say you feel frustrated easily when something does not go your way?	1 2 3 88 99	Often Sometimes Never Don't Know No Response
6.10	How often would you say that you - become easily angry?	1 2 3 88 99	Often Sometimes Never Don't Know No Response
6.11	How often do you feel hopeful about the future?	1 2 3 88 99	Often Sometimes Never Don't Know No Response
6.12	In the last 2 weeks, did you have trouble falling asleep?	1 2 88 99	Yes No Don't know No Response
6.13	How many times have you ever run away from home?		Specify no of times_____
7.1	**7.0 Protection and Rights** Do you know your date of birth? ***(If "no" or "don't know" - skip to Q7.4)***	1 2 88 99	Yes No Don't Know No response
7.2	On what day, month and year were you born?		Day_____ Month _____Year_____
7.3	Do you have a birth certificate?	1 2 88 99	Yes No Don't Know No Response
7.4	Have you ever been forced to engage in economic activities? (e.g. hawking, begging etc)	1 2	Yes No

		88 99	Don't Know No Response
7.5	Has someone beaten you for refusing to run errand for him/her?	1 2 88 99	Yes No Don't Know No Response
7.6	Have you ever been chased out of home?	1 2 99	Yes No No Response
7.7	Are you aware of a law protecting you as a child?	1 2 88 99	Yes No Don't know No Response
	8.0 KNOWLEDGE, ATTITUDES AND PRACTICES (KAP) ABOUT HIV/AIDS AND RISK-TAKING		
8.1	Have you heard of HIV/AIDS? ***(If no, skip to Q8.4)***	1 2 99	Yes No No Response
8.2	Has anyone ever discussed HIV/AIDS & related issues with you?	1 2 88 99	Yes No Don't know No Response
8.3	If yes, with whom do you discuss HIV/AIDS & related issues? (Do NOT prompt. Circle as many as child mentions)	1 2 3 4 5 6 88 99	Friends/peers Parent (s) Siblings Caregiver/maid Teacher Other (Specify) Don't know No Response
8.4	Would you be willing to eat from the same plate with a person you knew has HIV/AIDS?	1 2 88 99	Yes No Don't know No Response
8.5	If a close friend or relative of yours has HIV/AIDS would you be willing to care for him/her?	1 2 88 99	Yes No Don't know No Response
8.6	Mention possible means of HIV transmission ***(Circle all that are mentioned, do not prompt)***	1 2 3 4 77 88 99	Sexual intercourse Blood transfusion Sharing of sharp object e.g. needle, razor Mother to Child Others(specify)_____ (note misconceptions) Don't Know No response
8.7	Mention possible ways of preventing HIV ***(Circle all that are mentioned, do not prompt)***	1 2 3 4 5 77 88 99	Abstaining from sex Being Faithful to one sexual partner Using condom during sexual intercourse Not receiving unscreened blood Using new razor and needle Other (Specify)_____ *(note misconceptions)* Don't know No Response

8.8	***FOR CHILDREN AGES 13-17 ONLY*** Do you have a boy/girl friend? ***(If no, skip to Q8.13)***	1 2 88 99	Yes No Don't Know No Response
8.9	Have you ever been alone with him or her?	1 2 88 99	Yes No Don't Know No Response
8.10	Have you ever had sexual intercourse? ***(If no, SKIP to 8.14)***	1 2 88 99	Yes No Don't Know No Response
8.11	Have you ever had sexual intercourse against your will?	1 2 88 99	Yes No Don't Know No Response
8.12	Do you use condom when you have sexual intercourse?	1 2 88 99	Yes No Don't know No Response
8.13	How often do you use a condom when you have sexual intercourse?	1 2 3 4 5 88 99	All the time Sometimes Very rarely Never/Not at all Used it only once Don't Know No Response
8.14	Describe what a condom is used for?	1 2 88 99	Correctly answers (prevent pregnancy, protect against HIV and other STIs) Incorrect answers Don't know No response
8.15	What is abstinence? ***(If incorrect or don't know, SKIP to 8.17)***	1 2 88 99	Correctly answers (not having sex) Incorrect answers Don't know No response
8.16	Do you practice abstinence?	1 2 88 99	Yes No Don't know No response
8.17	Have you ever smoked cigarettes or any kind of tobacco? ***(If No skip to Q8.19)***	1 2 88 99	Yes No Don't Know No Response
8.18	(If Yes) – How often?	1 2 3 4 88 99	Less than once a week More than once a week Everyday On special occasions Don't Know No Response
8.19	Do you take any alcoholic drinks? ***(If no, skip to Q8.21)***	1 2 88 99	Yes No Don't Know No Response
8.20	How often do you take alcoholic drinks?	1 2 3 4 88 99	Less than once a week More than once a week Everyday On special occasions Don't Know No Response

8.21	Have you ever taken any illicit/hard drugs? ***(Give examples of drugs to include narcotic substances, etc)*** ***(If yes, continue)***	1 2 88 99	Yes No Don't Know No Response
8.22	Mention the drugs you have tried?		Specify_____

End Time: _____ Supervisor signature: _____

14.3.2 Questionnaire for Heads of Households/Caregivers

Serial number ☐☐☐☐
State_____ Diocese _____

Local Government Area _____ Parish _____

Name of Community _____
Date: _____ Start Time: _____

****

Consent Form

Hello! I am ____ and my partner is _____. We are here on behalf of ----------. We're talking with adults and children to get information about their lives and how they have been coping, especially in difficult times. Have you been interviewed in the past two weeks for this study on the same issue? (Clarify what study and except of a different issue, end the interview).

We would like to ask you a few questions about your life and the lives of your children. We are asking these questions so that we can understand the situation better and be able to develop support programs. The questions for you will take only some minutes. If you agree to take part in this interview, whatever you tell us will be confidential. However, your answers will be very important to us. We'll be asking adults and children from many other parts of Nigeria the same questions. When the survey is finished, we will collect all the responses we have received in (name of community) and keep them safe. Someone in the office will add them together. You will be able to find out about the results by contacting (name of local partner). Do you have any questions?

Are you willing to participate in this survey?

YES ☐ NO ☐

(If the response is 'No', thank the interviewee and end the interview).
We would also like to talk to some of your children, which will also take some minutes. Their answers are also completely confidential and private. The name of the child will not be written on this form. The child does not have to answer any questions that he or she does not want to answer and may end the interview at any time. Are you willing to let some of the children participate?

YES ☐ NO ☐

Signature of Interviewer _____ Date _____
(Certifying that informed consent has been given verbally by respondent)

(Optional)
Signature of Interviewee _____ Date _____
(I choose to give signed consent)

Thank you.

1.0 HOUSEHOLD LISTING MODULE

Use the under listed codes to fill observations and responses to section 1.

Sex	*Relationship With HH*	*Care givers*	*Highest level of Educ reached*	*Marital status*	*Other questions*	*Occupation*
Male 1	Child 1	Mother 1	No formal Education 1	Single 1	Yes 1	Civil servant 1
Female 2	Step-child 2	Father 2	Primary 2	Married 2	No 2	Farmer 2
	Grandchild 3	Step-mother 3	Modern 3	Separated 3	Don't know 88	Trader 3
	Nephew/Niece 4	Step-father 4	Secondary 4	Divorced 4	No response 99	Artisan 4
	Foster child 5	Grandfather 5	Post sec/A level 5	Widowed 5		Business 5
	Maid 6	Grandmother 6	Degree & Above 6			Clergy 6
	Worker 7	Guardian 7				Housewife 7
	Wife 8	Sister 8				Caregiver/rmaid 8
	Husband 9	Brother 9				Jobless 9
	Father 10	Maid 10				Other(s) 77
	Mother 11					Specify _____

1.1 Please, give the following information about the **children (under 18 years)** in this household using the provided spaces and note where are there are more people.

S/n	First name	Sex	Age	Relation-ship with HH	Educational status				Is the Biological father alive?	Does the father live in this house?	Is the Biological mother alive?	Does the mother live in this house?	Who Cares for the Child?
					Never In school	Out of School	In School	Current Class					
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													

1.2 Please, give the following information about **other members (adults)** of this household using the provided spaces and note where there are more people.

S/n	First name	Sex	Age	Relationship with HH	Educational status				Marital status	No of Biological children	No of Biological children living	Occupation
					Never In school	Out of school	Currently in school	Highest level				
1												
2												
3												
4												
5												
6												
7												
8												

2.0 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENT

S/No	Questions and Filters	Coding Categories	
2.1	How old were you at last birthday?		_____ years
		88	Don't Know
		99	No response
2.2	Sex of the respondent	1	Male
		2	Female
2.3	Are you the head of this household? ***(If yes, skip to Q2.5)***	1	Yes
		2	No
		88	Don't know
		99	No Response
2.4	What is your relationship with the household head?	Specify:_____	
2.5	What is your marital status? ***(If married continue, otherwise skip to Q2.7)***	1	Single/Never married
		2	Married
		3	Separated
		4	Divorced
		5	Widowed
		77	Other:_____
		88	Don't know
		99	No Response
2.6	How old were you when you first married? ***(If one wife, skip to Q2.9)***		Age in years:_____
		88	Don't know
		99	No response
2.7	How many wives/co-wives are in this household?	Specify the no:_____	
2.8	Do all the wives live in this house?	1	Yes
		2	No
		88	Don't know
		99	No Response
2.9	What is your religion?	1	Islam
		2	Christian: Catholic
		3	Protestant
		4	Pentecostal
		5	Other Christian (specify)_____
		6	Other religions (specify):_____
		88	Don't know
		99	No Response
2.10	What is your ethnic group?	Specify:_____	
2.11	What language do you speak most of the time?	Specify:_____	
2.12	What is your MAIN occupation?	1	Civil servant
		2	Farmer
		3	Trader
		4	Artisan
		5	Business
		6	Clergy
		7	Housewife
		8	Caregiver/Maid
		77	Others_____
		88	Don't know
		99	No Response
2.13	On an average, how much do you earn per month?	1	Below N5000
		2	Between N5000 & N10000
		3	Between N10001 & N20,000

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		4	Between N20001 & N30,000
		5	Between N30001 & N40000
		6	More than N40000
		88	Don't know
		99	No response
2.14	Kindly estimate the households' current total monthly income	1	Below N5000
		2	Between N5000 & N10000
		3	Between N10001 & N20,000
		4	Between N20001 & N30,000
		5	Between N30001 & N40000
		6	More than N40000
		88	Don't know
		99	No response

3.0 GENERAL LIVELIHOOD

3.1	What is the main source of drinking water for members of this household?	1	Pipe in dwelling
		2	Hand pump/borehole nearby
		3	Dug well in the compound
		4	Tanker/vendor
		5	River/Stream
		77	Other(specify)_____
		88	Don't Know
		99	No Response
3.2	Who fetches the water for household use MOST of the time? ***(Circle as many as applicable)***	1	Mother of household
		2	Grandmother of household
		3	Other adult female of household
		4	Father of household
		5	Grandfather of household
		6	Other adult male of household
		7	Female child (biological child)
		8	Female child (non-biological)
		9	Male child (biological child)
		10	Male child (non-biological)
		11	Maid
		12	Worker
		88	Don't know
		99	No response
3.3	What kind of toilet do you use?	1	Flush/water system
		2	Pit latrine
		3	Bush
		77	Other (specify)_____
		88	Don't know
		99	No response
3.4	Who cleans the toilet MOST of the time?	1	Mother of household
		2	Grandmother of household
		3	Other adult female of household
		4	Father of household
		5	Grandfather of household
		6	Other adult male of household
		7	Female child (biological child)
		8	Female child (non-biological)
		9	Male child (biological child)
		10	Male child (non-biological)
		11	Maid
		12	Worker
		88	Don't know

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		99	No response
3.5	What type of refuse disposal system do you use in this household?	1 2 3 77 88 99	Bin collected by agents Disposal pit within the compound Refuse dump Others (specify):_____ Don't know No response
3.6	Who disposes the refuse MOST of the time?	1 2 3 4 5 6 7 8 9 10 11 12 77 88 99	Mother of household Grandmother of household Other adult female of household Father of household Grandfather of household Other adult male of household Female child (biological child) Female child (non-biological) Male child (biological child) Male child (non-biological) Maid Worker Others (Specify):_____ Don't know No Response
3.7	What do you use to generate fire to cook your food most of the time?	1 2 3 4 5 77 88 99	Electric Gas Kerosene Firewood Charcoal Other(specify) _____ Don't know No Response
3.8	What is your main source of lighting?	1 2 3 4 5 77 88 99	Electric Candle Kerosene lantern Gas lamp Rechargeable lantern Other (specify) _____ Don't know No Response

4.0 CARING FOR CHILDREN AND ACCESS TO SUPPORT

4.1	How many children are you caring for?		Boys_____ Girls_____
4.2	What do you see as the greatest challenge in caring for these children	1 2 3 4 5 6 77 88 99	Financial problems Sickness Shortage of food School requirements Discipline Emotional problems Other (specify) _____ Don't know No Response
4.2	How often do the children under your care fall sick?	1 2 3 4	Very often Often Rarely Never

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		88	Don't know
		99	No Response
4.3	How/where do you normally treat them when they fall sick?	1	Treated at home
		2	Traditional Healer
		3	Patent medicine shop
		4	Primary health clinic/CHEW
		5	Gen Hospital
		6	Private hospital
		77	Others(specify)_____
		88	Don't know
		99	No Response
4.4	Who normally pay for the treatment?	1	Parents (Father/Mother)
		2	Guardian/caregiver
		3	Grandmother/father
		4	Relative
		5	Church/mosque
		6	Treatment is free
		77	Other(specify) _____
		88	Don't know
		99	No Response
4.5	How much money was spent on health care for these children in the last 30 days?	Amount in Naira_____	
4.6	How much money was spent on the children's education since the beginning of this school year?	Amount in Naira_____	
4.7	Do you have under your care a child(ren) who is (are) not your biological/natural children? ***(If no, skip to Q4.25)***	1	Yes
		2	No
		88	Don't know
		99	No Response
4.8	How many children whose parent(s) have died are under your care? (In number)	Total _____ Male_____ Female_____	
4.9	How many children whose parents are alive but are in need are under your care?	Total _____ Male_____ Female_____	
4.10	When did you assume the responsibility of caring for them?	1	More than 24 months
		2	Between 12 and 24 months
		3	Between 6 to 12 months
		4	Less than 6 months
		88	Don't Know
		99	No Response
4.11	What changes have taken place in the home since the arrival of these children? (Circle as many as applicable)	1	More Assistance for the Family
		2	House more crowded
		3	More children to play with
		4	More fighting
		5	Less food for every body
		6	More hands for house work
		77	Other (specify) _____
		88	Don't know
		99	No Response
4.12	Are there any conflicts between the children you have taken in and your own children?	1	Yes
		2	No
		88	Don't know
		99	No Response
4.13	What are the common causes of these conflicts?	1	Housework
		2	Jealousy

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		3 77 88 99	Fighting over food Other (specify) _____ Don't know No Response
4.14	How often do these conflicts happen?	1 2 3 4 88 99	Very often Often Rarely Never Don't know No Response
4.15	Compared to your own biological children, do you think the child(ren) you have taken in feel worried more often?	1 2 66 88 99	Yes No Not applicable Don't know No Response
4.16	Compared to your own biological children, do you think the child(ren) you have taken in feel unhappy/sad more often?	1 2 66 88 99	Yes No Not applicable Don't know No Response.
4.17	Compared to your own biological children, do you think the child(ren) you have taken in act disobediently at home more often?	1 2 66 99	Yes No Not applicable No Response.
4.18	Compared to your own biological children, do you think the child(ren) you have taken in become very angry more often?	1 2 66 88 99	Yes No Not Applicable Don't know No Response.
4.19	Do you think the child(ren) you have taken in have any special/unmet needs? ***(If no Skip 4.21)***	1 2 66 88 99	Yes No Not applicable Don't know No Response
4.20	What are these needs?	1 2 3 4 5 6 7 77 88 99	Health/Medical care Emotional support Spiritual support Nutrition Shelter Educational Vocational Other(specify) _____ Don't know No Response
4.21	Are you receiving any form of assistance from outside your household for the care of children under your care? ***(if no, skip to Q4.25)***	1 2 88 99	Yes No Don't know No Response

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4.22	If yes, where?	1 2 3 4 5 77 88 99	Relatives Church/mosque organization Government Neighbours /Community NGO Others (specify) _____ Don't know No response
4.23	What kind of assistance? (Circle all that are applicable)	1 2 3 4 5 77 88 99	Food Education Medical care Money Clothing Counselling & Emotional support/ Other (specify) _____ Don't know No response
4.24	How do you share the assistance given to you among the children?	1 2 3 88 99	Orphans only Vulnerable children only All children Don't know No response
4.25	Do you know of any organizations or groups of people providing assistance to orphans in this community?	1 2 88 99	Yes No Don't know No Response
4.26	Please, tell me the names of such organizations		_____ _____ _____ _____
4.27	Are you aware of a law protecting the rights of children in Nigeria?	1 2 88 99	Yes No Don't know No Response

5.0 KNOWLEDGE, ATTITUDES AND PERCEPTION OF CAREGIVER ABOUT HIV/AIDS AND RELATED ISSUES

5.1	In the past 2 years, have you seen an increase in the number of orphans living in your community?	1 2 88 99	Yes No Don't know No Response
5.2	What do you think are the main reasons that more children are being orphaned in this community?	1 2 3 4 5 77 88 99	Malaria Accidents HIV/AIDS Chronic diseases Death during child birth Other (specify) _____ Don't know No Response
5.3	In the past 2 years, have you seen an increase in the number of children in need living in your neighbourhood?	1 2 88 99	Yes No Don't know No Response.
5.4	What do you think are the main reasons that there are more	1	Malaria

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	children in need in this community?	2 3 77 88 99	Death of parents Chronic diseases Other (specify) _____ Don't Know No Response
5.5	If a relative of yours were infected with HIV, would you want it to remain a secret?	1 2 88 99	Yes No Don't know No Response
5.6	Do you have any close friends or relatives that you suspect are living with HIV &AIDS?	1 2 88 99	Yes No Don't know No Response
5.7	If a relative of yours became very ill with AIDS, would you be willing to care for him/her in your household?	1 2 88 99	Yes No Don't know No Response
5.8	If a close friend or relative of yours died of AIDS would you be willing to care for his/her child(ren) in your household?	1 2 88 99	Yes No Don't Know No Response
5.9	Would you be willing to eat from the same plate with a person you knew has HIV/AIDS?	1 2 88 99	Yes No Don't know No Response
5.10	Can you tell if someone has HIV /AIDS?	1 2 88 99	Yes No Don't know No Response
5.11	Do you know how to prevent HIV/AIDS	1 2 8 8 9 9	Yes No Don't know No Response
5.12	How can you prevent HIV/AIDS		_____ _____ _____ _____ __
5.13	Do you have any close friends or relatives that have died of AIDS?	1 2 88 99	Yes No Don't know No Response
5.14	What are the main concerns facing your community with regards to HIV&AIDS	1 2 3 4 5 77 88 99	Problem is getting worse Not enough being done People are too afraid of it There is a lot of discrimination Not enough information Other (specify) _____ Don't know No Response
5.15	Do you feel that children should know about HIV/AIDS and related issues	1 2 88	Yes No Don't Know

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		99	No Response
5.16	Do you discuss about HIV/AIDS and related issues in your family?	1 2 88 99	Yes No Don't Know No Response
5.17	Do you talk to/discuss with the children in your household about HIV/AIDS.	1 2 88 99	Yes No Don't know No Response

End Time _____ Supervisor signature _____

14.3.3 FOCUS GROUP DISCUSSION GUIDE FOR CAREGIVER

1. Tell us if children are losing their parents more than before in this community (Probe for reasons)

2. In your locality/community, what are the words/names for a child who has lost (i) both parents (ii) one parent?

3. How are children who have lost their parents cared for in the community?
   What provisions or arrangements are made for them in this culture/community?

4. What problems do children who have lost one or more of their parents face? (Allow for free-listing)
   - How are these problems different from the problems of other children whose parents are still alive?
   - Are there other groups of children in this community who are not orphans but also face the same/similar problems? Who are they? Where can one find them?
   - What else could be done to improve the situation?

5. Do you know of any groups of people or organizations taking care of orphans and other vulnerable children in this community other than your family?
   -How are the problems of orphans and other vulnerable children being addressed by various groups in your community such as government, church, or other community and non-governmental organizations?

6. In what ways has taking on extra children impacted or affected your own family?
   - What differences do you experience between looking after boys or girls?
   - In what ways has taking care of extra children helped your family?

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- How would you describe the relationship between the child(ren) you have taken in and your own biological children? How often do they quarrel? What are the major causes of the conflicts?

7. How do families taking care of orphans manage or cope? If/when families need assistance, where do they get it from?

8. What are some of the problems you have noticed in the children you have taken in and how do you help them? How do you help them to deal with the emotional pains surrounding the death of their parents/guardians?

9. Under what circumstances, if any, would you turn away/reject the children you have taken in and ask them to leave your home or make alternative living arrangements for them?

10. Are children who have lost their parent(s) in danger of being cheated or exploited or abused? If so, how and by whom?
    - What about other vulnerable children? *(explain vulnerable children - like street kids and children with disabilities, etc.)*
    - What usually happens to people who cheat, exploit, or abuse children in this community?
    - *(if nothing is being done, further probe)* What is the community doing to change this?

11. In this community, what happens to the land/property/possessions of the father of a child when he dies? What about mother's property? What do you think of these practices?

12. In this community, do people discuss with parents about what should happen to their children when they die?
    - What sort of discussions do parents have about their children's future in case of their death?
    - How are the children involved in these discussions?
    - Do parents make any WILL or PLAN for the children?
    - How are the WILL or Plan followed? *(probe for challenges or difficulties)*

13. How serious is HIV and AIDS epidemic in this community? *(Probe for spread and impacts)*
    - In your community, what are the words/names people call HIV and AIDS and people living with the virus?

14. What do you discuss with the children in your care about HIV and AIDS, sex and reproductive health issues? Tell me about how you carry out the discussion.

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14.3.4 Focus Group Discussion Guide for OVC (9-12 years)

Icebreaker: Tell me about your everyday life?

Prompt: When do you get up? What do you do when you first get up? What do you do before school? What do you do after school?

1) Who takes care of you? How are you related to this person? Tell us more about this person.

2) What do you do when you have a problem?
   - Who do you talk to?
   - How do you feel when you talk to this person?
   - What type of problem(s) do you have?

3) How often do you go to school? What usually happens to make you miss school (in-school)? Why do you not go to school (Out of school)?

4) Have you been sick in the last three months? Can you tell us what happened? Did you get any treatment? Who paid for your treatment?

5) How do people in the community treat you?
   - Are you treated differently by the same sex? How?
   - Are you treated differently by the opposite sex? How?

6) What do you plan to be when you grow up?

14.3.5 Focus Group Discussion Guide for OVC (13 to 17 years of age)

1. In your locality/community, what are the words/names for a child who has lost (i) both parents (ii) one parent?

2. Tell us if children are losing their parents more than before in this community (Probe for reasons)

3. How are children who have lost one or more of their parents being treated in this community?
   - How are you treated differently from other children of your own age? *(lead children to narrate experiences)*

4. What problems do children who have lost one or more of their parents (like your self) face? *(Allow for free-listing)*

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- How are these problems different from the problems of other children whose parents are still alive?
- Who do you talk to when you have a problem? Describe what kind of problems you talk about with which people.
- How are these problems being addressed by various groups in your community such as the family, government, church, or other community and non-governmental organizations?
- Are there other groups of children in this community who are not orphans but also face the same/similar problems? Who are they? Where can one find them?
- What else could be done to improve the situation?

5. How has your living situation changed since your parent(s) died? If you are not living in your family home now, in what way has living in another family/household affected you? *(Probe in terms of living condition, emotional feelings etc)*

6. Describe your relationship with the children of your guardian? How often do you have conflicts? What are the major causes of the conflicts? How are the conflicts resolved?

7. Are children who have lost their parent(s) in danger of being cheated or exploited or abused? If so, how and by whom?
   - Have any of these things ever happened to you? What has been your experience with this?
   - What about other vulnerable children? *(explain vulnerable children - like street kids and children with disabilities, etc.)*
   - What usually happens to people who cheat, exploit, or abuse children who have lost their parents, in this community?
   - *(if nothing is being done, further probe)* What is the community doing to change this?

8. In this community, what happens to the land/property/possessions of the father of a child when he dies?
   - What about the mother's property?
   - What was your own experience?
   - What do you think of these practices?

9. Do parents discuss with other people about what should happen to their children if/when they die?
   - What discussions are you aware of that your parents had in order to make plans for your future before they died?
   - How were you involved in these discussions?
   - Did your parents make any WILL or PLAN for you?
   - How were the WILL or Plans followed? *(probe for challenges or difficulties)*

10. Let's talk about school:
    - How often do you attend school?
    - If you miss school, what makes you miss school?
    - How are you treated at school by other children? By teachers?
    - If you could change one thing at school to make it better for you, what would it be? (or What is the most difficult thing about school?)

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11. What happens when you fall sick?
    - Describe what happened the last time you fell sick. *(Probe into nature of sickness, source of treatment, person responsible for payment etc)*
    - How is this different from before you became an orphan?
    - How often do you fall sick?

12. What do you know about HIV and AIDS?
    - How did you get the information?
    - In what ways do you know that a person can get infected with HIV?
    - What can you do to protect yourself against getting infected with HIV?

13. How serious is HIV and AIDS epidemic in this community? *(Probe for spread and impact)*
    - In your community, what are the words/names people call HIV and AIDS and people living with the virus?

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