



ECEWS
...Improving Education and Health in Nigeria

STRENGTHENING RESILIENCE



**A Multi-sectoral Approach
to Health, Economic Stability,
and Protection**

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LIST OF ACRONYMS

ART	Antiretroviral Therapy
CBO	Community-Based Organizations
CCMP	Community Case Management Programme
CDC	Centre for Disease Control and Prevention
CALHIV	Children and Adolescents Living with HIV
CLHIV	Children Living with HIV
ECEWS	Excellent Community Education Welfare Scheme
EID	Early Infant Diagnosis
DCT	Data Capturing Tools
DEC	Data Entry Clerk
GH	General Hospital
HEI	HIV-exposed Infant
HIV	Human Immunodeficiency Virus
HUFFPED	Humanity Family Foundation for Peace and Development
IIT	Interruption in Treatment
IYCF	Infant and Young Child Feeding
LIWOM	Living Word Mission
MER	Monitoring and Evaluation Reporting
MAM	Moderate Acute Malnutrition
NDR	National Data Repository
NMRS	Nigeria Medical Records System
NOMIS	National CCMP Monitoring Information System
PIHO	Pediatrics Integrated Health Officer
PMTCT	Prevention of Mother-to-Child-Transmission
RULIN	Rural Linkage Network
SAM	Severe Acute Malnutrition
SPEED	Sustainable Program for HIV Epidemic Control and Equitable Service Delivery
TB	Tuberculosis
VC	Vulnerable Children
VP	Violence Protection

Introduction

Nigeria continues to face a substantial pediatric HIV burden. An estimated 2 million people are living with HIV in the country, including approximately 160,000 children aged 0–14 years, making Nigeria one of the countries with the highest pediatric HIV burden in West Africa(1, 2). In 2023 alone, an estimated 22,000 new HIV infections and approximately 15,000 AIDS-related deaths occurred among children aged 0–14 years in Nigeria®, reflecting persistent gaps in prevention of mother-to-child transmission (PMTCT), early diagnosis, and pediatric treatment coverage. Across Nigeria, vulnerable households, particularly those caring for Children and Adolescents Living with HIV (CALHIV), HIV-Exposed Infants (HEIs), and other highly vulnerable



children, face intersecting risks that undermine health outcomes and long-term stability(3-5). High HIV burden, persistent poverty, food and nutrition insecurity, exposure to violence, limited access to quality education, and weak social protection systems interact to disrupt treatment adherence and constrain life opportunities(6, 7). These challenges are most acute in resource-constrained settings where health systems are overstretched, and household coping mechanisms remain fragile®.

ECEWS responds to this complexity through a multi-sectoral resilience framework aligned with PEPFAR's 95-95-95 goals. Through its Community Case Management Program (CCMP), ECEWS strengthens HIV risk assessment and testing to improve case identification (first 95); supports linkage to and continuation on ARV drugs (second 95); and supports viral load monitoring and suppression strategies (third 95). These services are reinforced with nutrition support, household economic strengthening, education assistance, and protection interventions that address structural barriers such as poverty, food insecurity, stigma, and violence that impede sustained treatment outcomes.

Implemented across three states, the CCMP operationalizes a robust community–facility alignment model, linking health facilities, community-based organizations, government ministries, and local structures through coordinated referral networks. This integrated, people-centered approach improves treatment continuity and viral suppression among CALHIV and caregivers, strengthens household income and food security, enhances school attendance and adolescent life skills, and expands access to survivor-centered protection and social welfare services. Collectively, the CCMP supports treatment efforts on HIV epidemic control, while reinforcing household resilience, community ownership, and sustainable social protection systems in line with national priorities and PEPFAR's vision for sustained impact.

Gaps Between Clinical Care and Household-Level Social and Economic Vulnerabilities

Several underlying social and economic vulnerabilities significantly influence health outcomes and treatment adherence among CALHIV and HEIs[®]. Key gaps included the lack of systematic household-level risk assessment and stratification to identify the most vulnerable families; fragmented service delivery; insufficient attention to non-clinical barriers such as food insecurity, school dropout, economic instability, and lack of transportation; absence of individualized, family-centered care plans that addressed the unique needs within each household; and limited mechanisms for continuous follow-up, monitoring, and early identification of treatment challenges (3, 4, 10).

Gaps in Synergy Between Facility-Based Services and Community Support

Beneficiaries were frequently lost between service delivery points due to weak linkages and poor coordination between facility-based clinical services and community-level support systems. Health facilities and community structures operated in silos with limited communication. This lack of synergy meant there was insufficient community-level reinforcement of facility-based clinical interventions due to weak structured referral mechanisms, follow-up systems, and feedback loops. This leads to suboptimal treatment outcomes and viral suppression rates, especially among clients who experienced treatment barriers or required additional support.

Gaps in the Integration of Violence Prevention and Response into HIV Programming.

Violence screening is not systematically integrated into HIV service delivery platforms, resulting in survivors going unrecognized within the healthcare system. This leads to missed opportunities for early intervention and comprehensive care that could prevent both the immediate trauma and long-term health consequences. Even when cases were identified, survivors face multiple barriers, including a lack of coordinated referral pathways; insufficient capacity among healthcare providers to provide trauma-informed, survivor-centered care; limited access to integrated clinical services; and limited linkages to non-clinical support.

Gaps Between Information Collection and Evidence-Based Program Adaptation

Fragmented data systems that lack client-level tracking and longitudinal cohort monitoring, multiple data platforms and siloed information management that prevents holistic understanding of beneficiary needs and service delivery gaps are some of the gaps that limit optimal care for CALHIV.



Approaches/ strategy and key interventions

Integrated Case Management (ICM)

Achieving HIV epidemic control and long-term household resilience requires more than clinical service delivery; it demands a structured response to the social and economic vulnerabilities that influence health outcomes. Hence, the Integrated Case Management (ICM) approach places the households of Children and Adolescents Living with HIV (CALHIV) and HIV-Exposed Infants (HEIs) at the center of intervention, recognizing that sustainable treatment outcomes are also shaped by conditions within the home and community.



Through routine household assessments and risk stratification, trained Community Case Managers in partner Community-Based Organizations (CBOs) identify and prioritize the most vulnerable households and develop individualized care plans to link them to a coordinated package of need-based services. These services include HIV risk assessment and testing, medication adherence monitoring, nutrition assessments and food demonstrations, educational enrollment, household economic strengthening interventions (such as cash transfers for indigent households), income-generating activities, and VSLA participation, etc. Other forms of services available include home-based services, transport support for indigent households, appointment reminders, assisted referral, support for Enhanced Adherence Counselling (EAC), and routine Case Conferencing.



Community–Facility Synergy

The community–facility alignment model under the CCMP is bi-directional and ensures no beneficiary is lost between service points. Community-Based Organizations (CBOs) work closely with supported health facilities to facilitate referrals, follow-up, and feedback loops for HIV services, including HIV testing, ART initiation, viral load monitoring, TB screening, etc. They utilize home visits, assisted referrals, appointment reminders, and case conferencing to support beneficiaries in achieving optimal treatment outcomes.

Violence Prevention & Post-Violence Care Mainstreaming

Violence prevention is fully integrated into ECEWS’s service delivery model to identify and mitigate HIV epidemic control barriers linked to violence. Routine screening for different forms of violence, including violence against children, is conducted across community and facility platforms. Intimate Partner Violence (IPV) identification is further integrated into the EAC and ANC/PMTCT program. Survivors are provided with first-line support (LIVES) and linked to clinical care (HTS, PEP, STI, Treatment of injuries, and Mental health services), and non-clinical care (legal services, shelter, and social welfare structures) is also provided.



Continuous capacity building of CBO staff, facility focal persons, and government actors strengthens survivor-centered response. Birth registration support, adolescent safe spaces, caregiver forums, and the establishment of the child protection committee (CPC) further reinforce child safeguarding and social protection outcomes and protect vulnerable children against abuse. Through awareness campaigns and behavior change interventions, including Information, Education, and Communication (IEC) strategies, safe adolescent spaces, and community outreach, individuals gain a critical understanding of their rights, develop the ability to recognize harmful norms and behaviors, and learn to promote non-violent relationships and gender equality.

We also strengthened referral pathways and inter-agency coordination among health facilities, law enforcement, social services, and civil society, resulting in more seamless, survivor-centered care. We further embedded Sexual and Reproductive Health (SRH) services, including Menstrual Health Management support, into the post-violence care response to address holistic survivor needs. These initiatives help reduce social tolerance for violence and empower individuals to seek help.

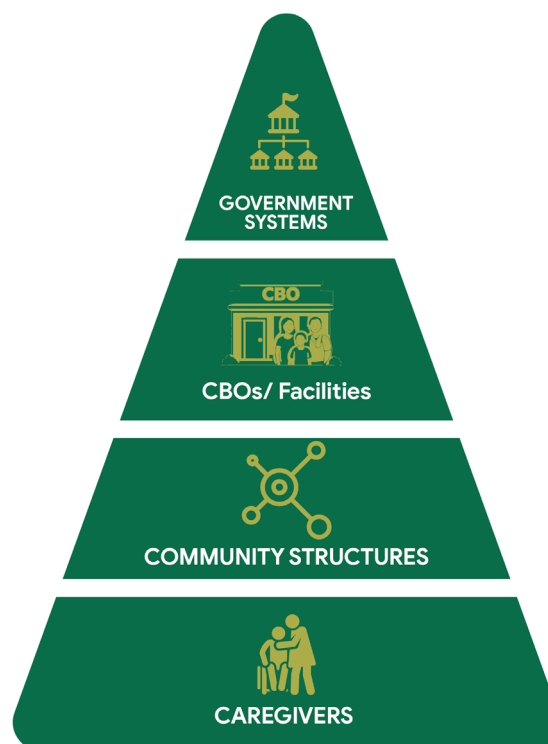


Data-Driven Decision-Making and Reporting

Data management within the ECEWS CCMP is anchored on the Nigeria OVC Management Information System (NOMIS), the national client-level platform for enrolled beneficiaries. NOMIS consolidates records for CALHIV, HEIs, and vulnerable households into a unified system that captures case management, service delivery, and clinical linkage information. Through routine monitoring, Data Quality Assurance (DQA), care plan reviews, and cohort tracking, teams systematically identify service gaps, missed appointments, unsuppressed clients, and households requiring intensified support.

Aggregate analyses by age, sex, geography, service domain, and clinical status enable near real-time monitoring of retention, viral suppression trends, and service coverage. Line lists generated from the NOMIS feed into a structured CCMP dashboard used for situation room meetings.

Sustainability, Localization & Collaboration

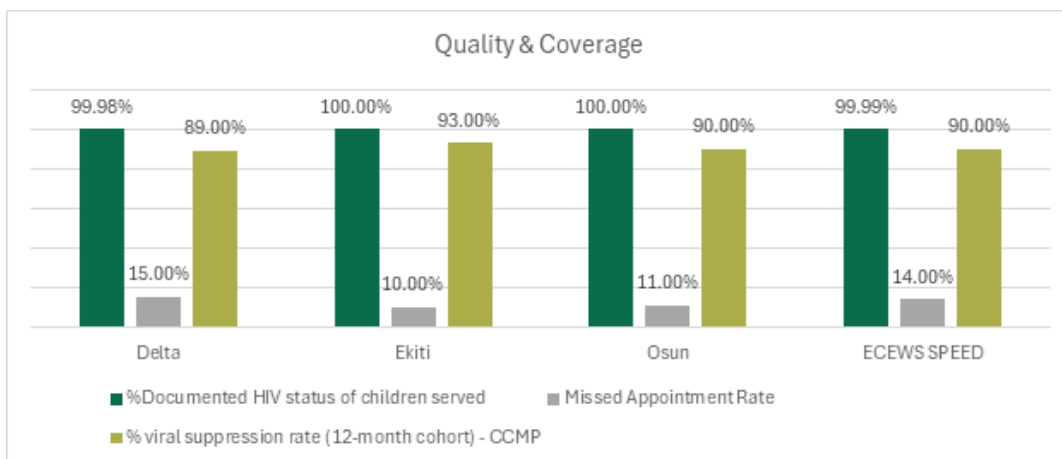
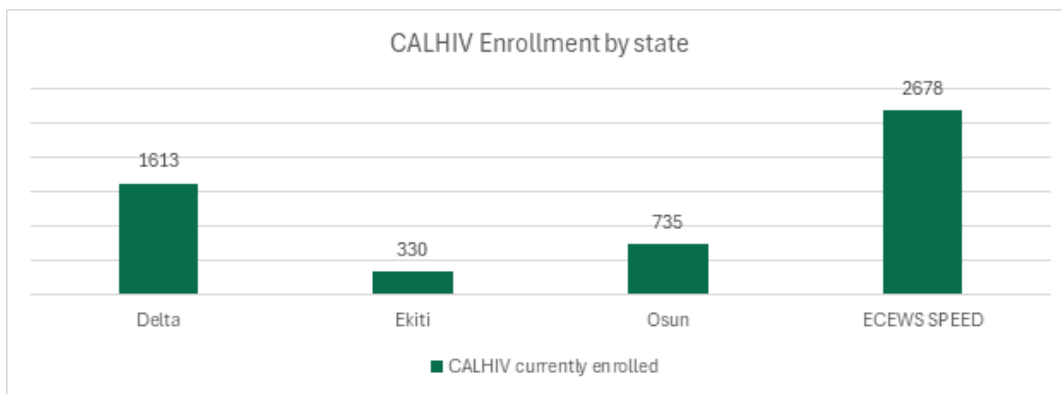
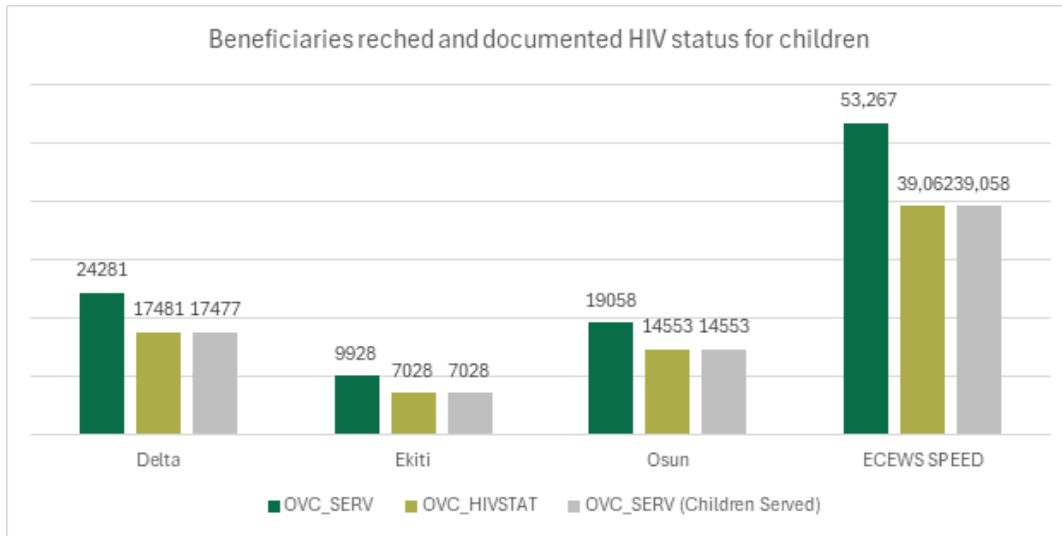


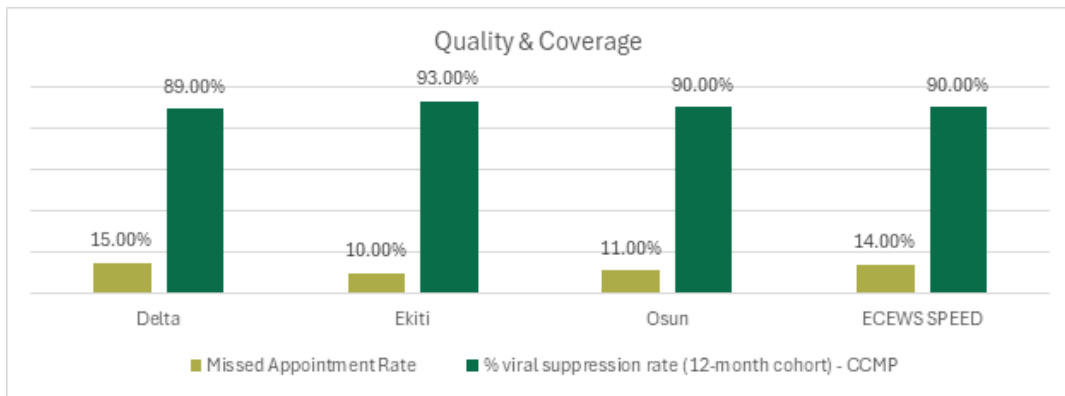
Sustainability/ Collaborations, Public-Private Partnerships (PPP), and Localization.

ECEWS partners with state ministries, community organizations, and other stakeholders to align service delivery with government priorities. The project enhances the capabilities of local actors through targeted training in comprehensive case management, data use, and violence prevention. Additionally, it supports community platforms, promotes financial literacy, and fosters self-reliance. A key aspect of the project's success is its multi-sectoral collaboration, working with health facilities, state HIV programs, and community organizations. In partnership with the National Agency for the Control of AIDS, ECEWS established the Gender and Human Rights Response Committee, which aims to improve the response to gender-based violence through better service coordination and referral pathways.

Achievements (Data/ visual impact)

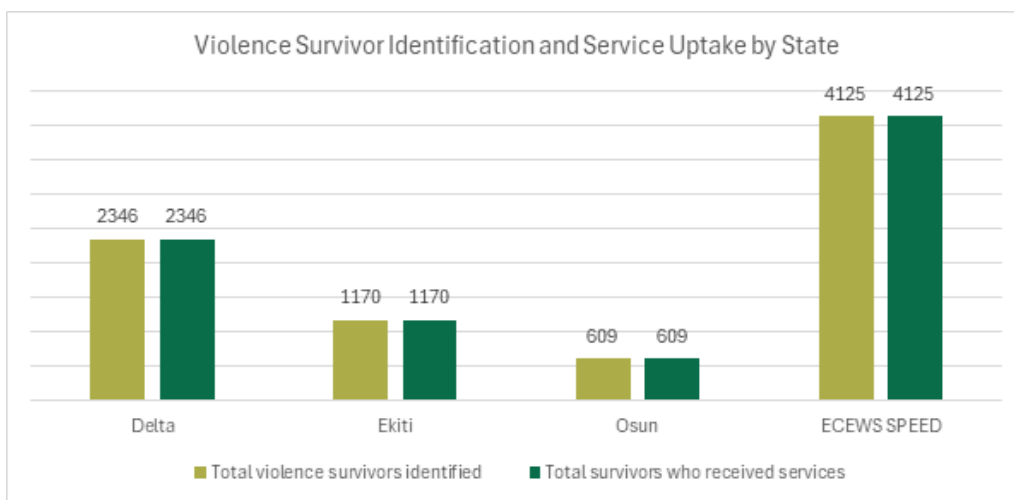
Improved HIV Treatment Outcomes



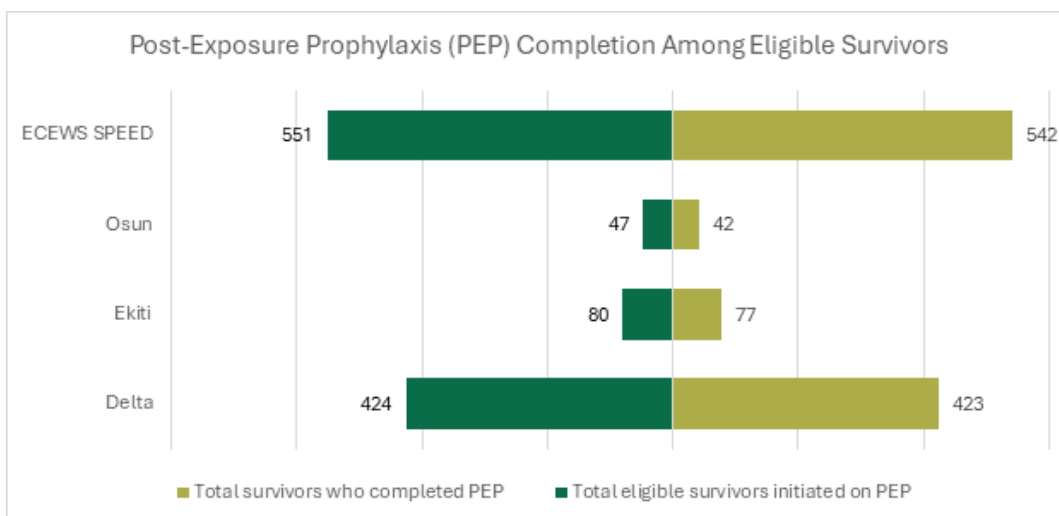


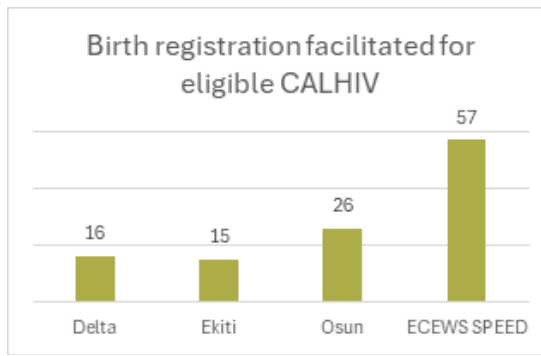
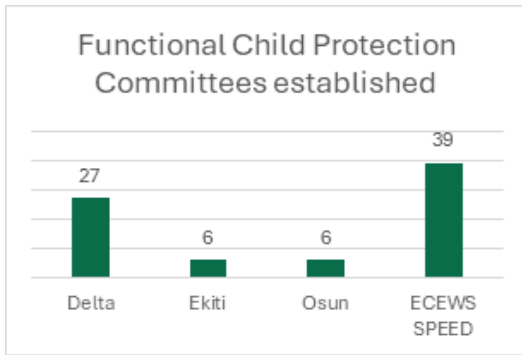
Enhanced Protection and Child Safeguarding

This section summarizes survivor identification, post-violence clinical response, and child protection system strengthening outcomes.



All identified survivors received services (100% linkage across states).





Key Protection Highlights – FY25 Q4

4,125

survivors identified and linked to services

High PEP completion among eligible survivors

39

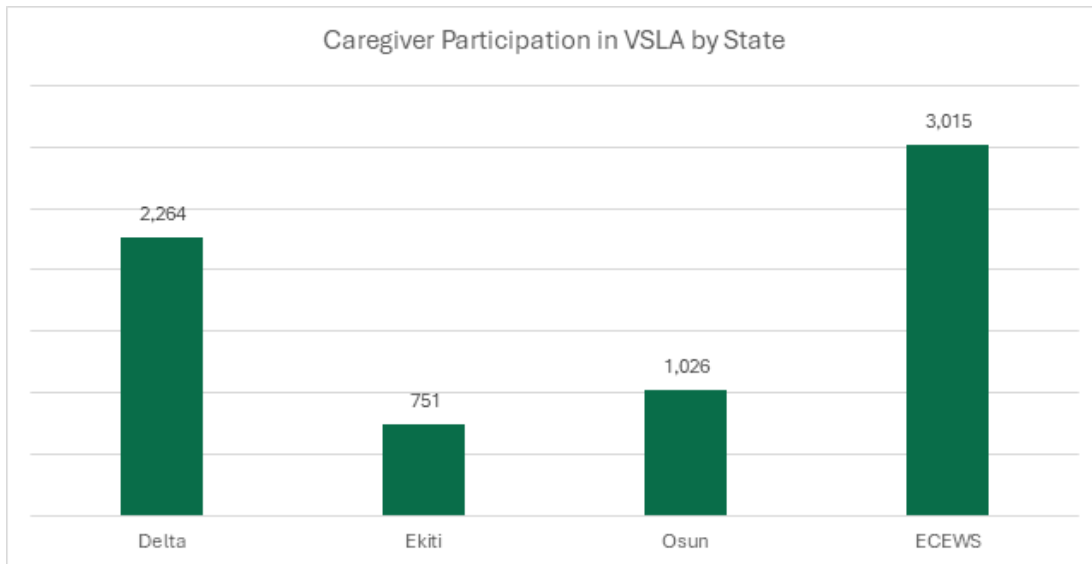
Child Protection Committees functional

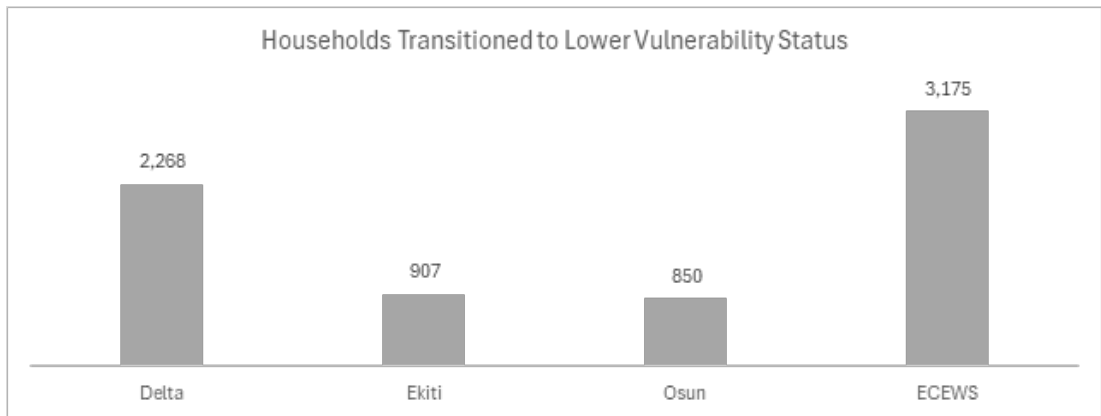
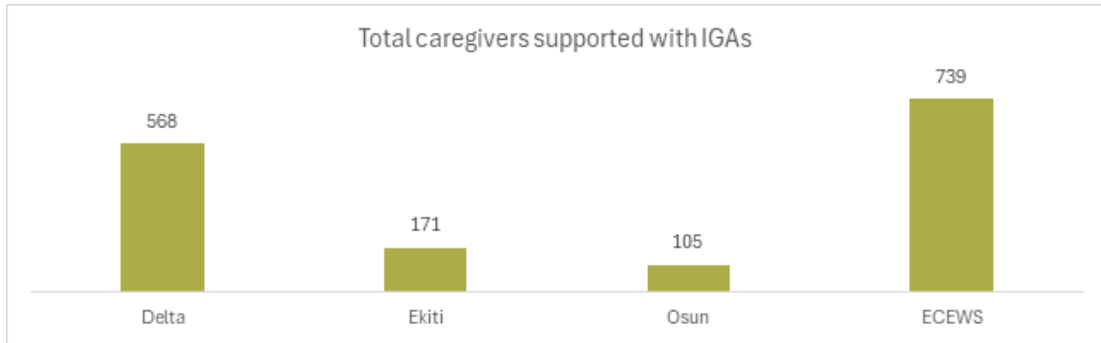
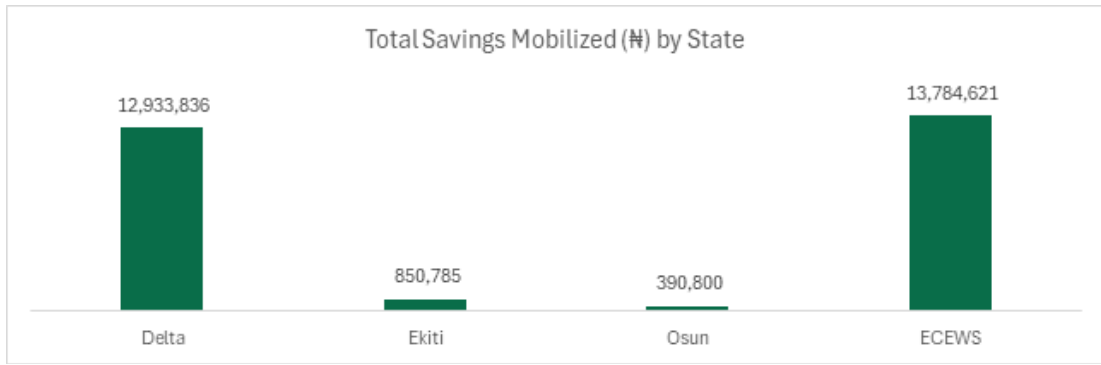
57

CALHIV supported with birth registration

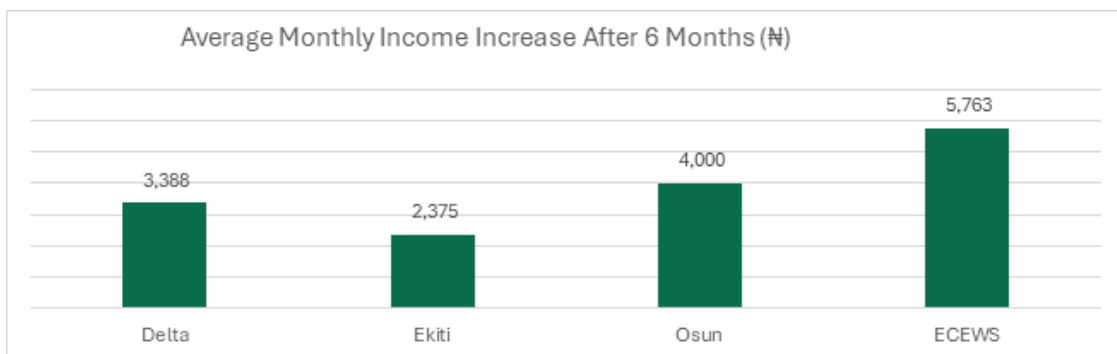
Strengthened Household Economic Resilience

Summary of VSLA participation, livelihood support, and household economic transition outcomes.





3,175 households improved vulnerability classification across states.



Income growth is highest in Osun; steady gains across all states.

Key Economic Strengthening Highlights – FY25 Q4

3,015

caregivers
enrolled in
VSLA

N13.78M

savings
mobilized

739

caregivers
supported with
IGAs

3,175

households
transitioned to
lower
vulnerability

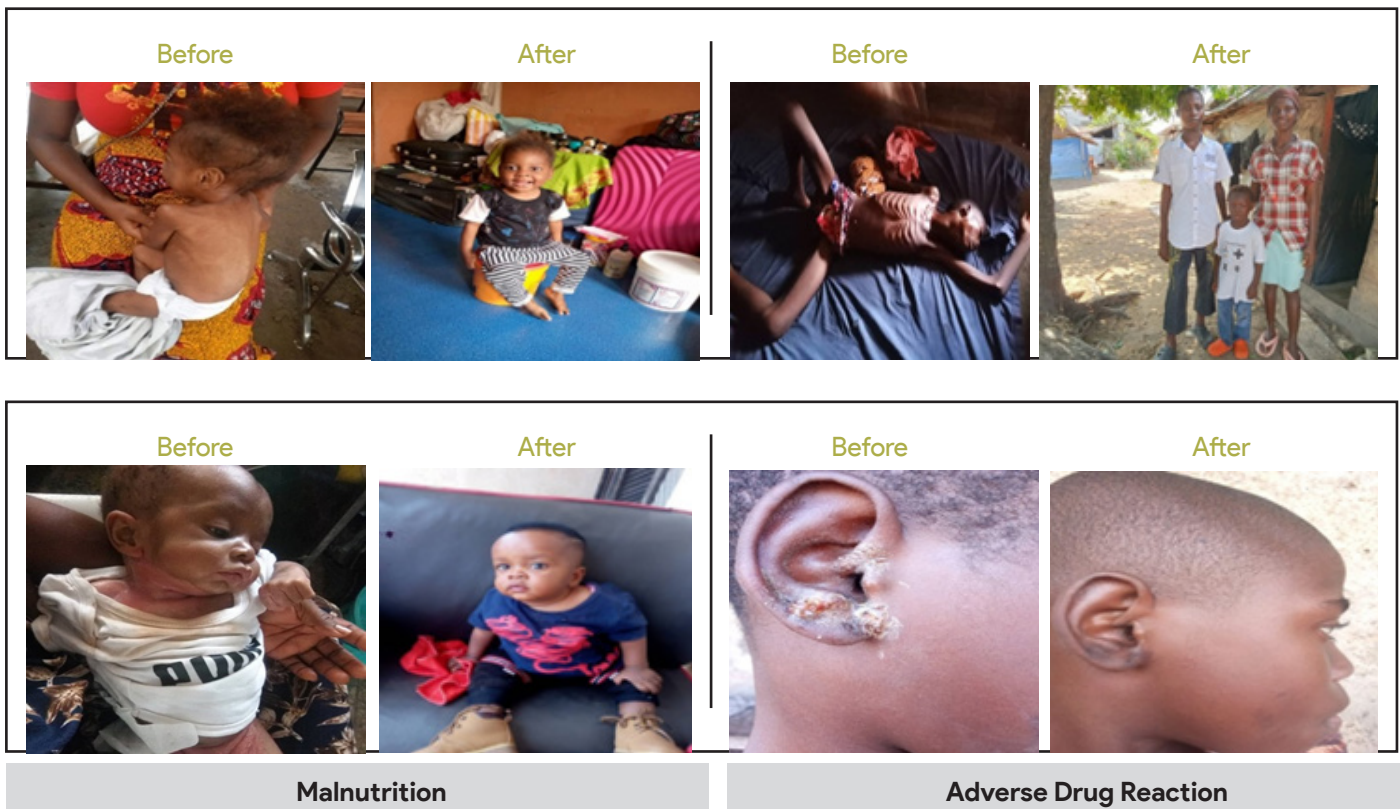
N5,763

average
income
increase
across states

Sustained Systems & Local Ownership	Delta	Ekiti	Osun	ECEWS SPEED
Total community case managers trained	186	36	30	222
Total health facilities supported	56	16	22	72

A Cross-Section of Visual Impact

HEALTH INTERVENTION



HES INTERVENTION



Irrigation farming (Livelihood support)

EDUCATION/ BLOCKGRANT INTERVENTION



Supported CALHIV with WAEC Fees

Adolescents in AYP Hub received Books support in their schools



Rehabilitation of the school water system (Borehole)



Production of chairs for CALHIV enrolled in Government Public Schools in Ekiti & Delta State



Lessons Learned

- Integrated, household-based services improve both health and social outcomes
- Economic strengthening is a critical enabler of ART adherence and retention
- Strong community–facility linkage improves viral load monitoring outcomes
- Routine data use at community and facility levels improves program quality.
- Virtual platforms are powerful, low-cost tools for real-time capacity building, information dissemination, and mentorship, enabling program continuity even under resource constraints.
- Multi-sectoral collaboration is a force multiplier: partnerships with government, CBOs, and the private sector expanded reach, improved livelihoods, and sustained services that no single actor could deliver alone.

Conclusion

ECEWS Community Case Management Program (CCMP) demonstrates that HIV epidemic control cannot be achieved through clinical interventions alone. Sustainable impact requires a deliberate integration of health services, household economic strengthening, protection systems, and community engagement. Across Delta, Ekiti, and Osun States, the intervention has operationalized this multi-sectoral model through strong community–facility linkages, data-driven decision-making, and collaboration with eleven CBO partners, government ministries, supported health facilities, and community leadership structures.

Through the CCM Program, thousands of vulnerable children, adolescents, and caregivers received comprehensive services, strengthening case identification, retention in care, adherence, and pathways to viral suppression. At the same time, economic strengthening interventions, including HEVA-guided support, VSLAs, COFE, vocational training, and start-up assistance, addressed the structural barriers that undermine sustained treatment outcomes. Integrated protection services, survivor-centered care, and coordinated referral systems reinforced child safeguarding and social protection mechanisms.

Importantly, ECEWS built the capacity of government and community actors, formalized referral pathways, and institutionalized coordination structures with NACA. These efforts position state and local systems to sustain gains beyond project funding.

The learnings from the project affirm a clear lesson: when health, economic stability, and protection are delivered together, through localized, accountable systems, vulnerable households move from fragility toward resilience. Continued partnership and investment will not only protect these gains but also accelerate progress toward sustained epidemic control and long-term community wellbeing.

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