GETTING TO GRADUATION!
TAKING A WHOLE SYSTEMS APPROACH TO SUPPORT ORPHANS AND VULNERABLE CHILDREN ACHIEVE SUSTAINED HOUSEHOLD RESILIENCY

As countries forge ahead toward 95-95-95 goals, overall HIV treatment coverage has increased over the past decade, leading to improved quality of life, more stabilized communities, and fewer children becoming orphans due to AIDS.\(^1\) However, specific populations, including orphans and vulnerable children (OVC), continue to face significant vulnerabilities due to HIV, driven by inequities in HIV service coverage and the socioeconomic impact on OVC households (HHs) that have lost one or both parents due to AIDS. Addressing these vulnerabilities requires curated, age-appropriate household- and community-based interventions to improve pediatric case-finding and strengthened treatment initiation and continuity for OVC, as well as enhanced access to vital social services and strengthened HH economic stability to improve the well-being of OVC and their caregivers.

Whereas Kenya has made significant strides in tackling its HIV epidemic—with a 57% reduction in new HIV infections and 68% decrease in AIDS-related deaths\(^{ii}\)—there is growing recognition for urgent action to address lingering equity gaps among priority populations, including children. This led Kenya to recently launch its Plan to End AIDS in Children by 2027, comprising a four-pronged plan to advance a multisectoral approach to tackle elimination of HIV, syphilis, and hepatitis; unintended pregnancies; and sexual and gender-based violence, while advocating for inclusion of benefits for children and women


living with HIV within socio-protection and social health insurance frameworks. In support of the United States President’s Emergency Plan for AIDS Relief’s (PEPFAR’s) “5x3” Strategy and efforts to build toward long-term sustained HIV impact, the government of Kenya (GOK) has concurrently committed to strengthening the resilience of its health system, namely by increasing domestic funding sources, enhancing the private sector’s role in sustaining HIV care, empowering counties to strengthen health budgeting, and enhancing the capacity of community structures and the health workforce to drive health and social service provision.

SUPPORTING ORPHANS AND VULNERABLE CHILDREN IN WESTERN KENYA

Approximately 85% of children living with HIV in Kenya are on antiretroviral therapy (ART), with 74% viral suppression observed among children living with HIV, far below the 95% benchmark. Treatment coverage and viral suppression also vary greatly between counties; for example, 2022 estimates for Migori County indicate 68% ART coverage for children living with HIV. Poor treatment coverage and viral suppression outcomes among children and their HH members living with HIV are driven by intersecting HIV and economic vulnerabilities, which range from poverty driven by dispossession of assets coupled with limited income-generating opportunities and links to business networks (particularly in the primarily rural and agricultural areas of Homa Bay, Kisii, Migori, Nyamira, and Vihiga counties) to weak financial literacy and life skills. These vulnerabilities play out against a backdrop of poor access to school and health care, increased violence, and weak social support systems, further increasing risk for vulnerable groups, particularly children and adolescents living with HIV, children exposed to HIV or who have experienced sexual violence, young mothers, and children of key populations.

With PEPFAR through the US Agency for International Development (USAID), PATH

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https://www.who.int/data/gho/data/indicators/indicator-details/GHO/estimated-antiretroviral-therapy-coverage-among-children
Kenya has been partnering with key national and county government stakeholders, implementing partners, and community-based organizations to advance progress toward HIV epidemic control in western Kenya since 2011. PATH Kenya currently leads the PEPFAR/USAID Nuru Ya Mtoto project, which uses a county-led approach to advance the GOK’s goal of addressing HIV and AIDS while safeguarding the rights and welfare, and building the resilience, of vulnerable families with children and adolescents affected by HIV and AIDS. Working through a PATH Kenya–led consortium of Kenyan nongovernmental organizations, USAID Nuru Ya Mtoto provides high-quality, integrated HIV services to people living with HIV, OVC, and adolescent girls and young women across seven counties in western Kenya. The project’s OVC component fast-tracks the provision of a wrap-around package of health, education, social protection, and economic strengthening services for OVC and their HHs in five counties—Homa Bay, Kisii, Migori, Nyamira, and Vihiga. By working under county leadership and through local implementing partners (LIPs) and community health workers (Community Health Promoters and OVC case workers), USAID Nuru Ya Mtoto actively embeds strengthened and sustainable county-level systems to ensure that OVC, their caregivers, and HHs can access health, education, economic, and social support services required to enhance their resilience and transition their HHs out of PEPFAR support.

**USING A MULTISECTORAL APPROACH TO ENHANCE CHILD, ADOLESCENT, AND HOUSEHOLD RESILIENCE**

The overall goal of PEPFAR’s OVC programming is to build the resiliency of families and children affected by HIV and AIDS so that they can meet their basic health, economic, education, and social development needs, while mitigating the impact of and preventing new infections among children most vulnerable to HIV. PEPFAR-funded programs prioritize interventions for “children who have lost a parent to HIV and AIDS, who are otherwise directly affected by the disease, or who live in areas of high HIV prevalence and may be vulnerable to the disease or its socio-economic effects.” This includes children living with HIV, biological children of HIV-positive mothers, pregnant and breastfeeding adolescents, survivors of sexual violence, adolescents living in a high HIV prevalence area, and at-risk children (e.g., children of key populations).

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PEPFAR programming for OVC serves the dual purpose of mitigating the impact of HIV on OVC while preventing HIV- and AIDS-related morbidity and mortality. Through a multisectoral case management approach to improve health, well-being, and protection while strengthening child, adolescent, and HH resilience, OVC are supported through a comprehensive, age-appropriate service package built around four domains: health, schooling, safety, and stability.

As depicted in Figure 1 above, upon enrollment and annually until graduation, case plans are co-developed and updated by OVC case workers and HH members for each HH enrolled in the comprehensive OVC program. Case plans are customized to each HH’s specific needs, co-identified by OVC case workers and HH members through a joint assessment and prioritization exercise, and dictate services provided to OVC HHs over the year to improve overall resilience and facilitate graduation. Annual case plan achievement and readiness assessments (CPARA), facilitated by OVC case workers, measure HH achievement of OVC benchmarks and determines readiness to graduate. The CPARA categorizes each OVC HH into one of four vulnerability categories, based on graduation benchmarks. Figure 2 summarizes these four categories and the suite of economic strengthening interventions offered at each phase to help HHs transition along the graduation pathway. Graduation is the point at which HH members and their case worker jointly agree that the HH has demonstrated the ability to meet basic OVC HH needs to a reasonable degree (quantitatively measured as having achieved all required graduation benchmarks) and is no longer in need of PEPFAR support.

**Figure 2: USAID Nuru Ya Mtoto’s HH graduation pathway.**

<table>
<thead>
<tr>
<th>HH vulnerability</th>
<th>Livelihood phase</th>
<th>ES approach</th>
<th>ES suite of offered services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ready to graduate (Score: 9)</td>
<td>Families attaining resiliency</td>
<td>Graduation (resilience monitoring)</td>
<td>Pre- and post-graduation monitoring for three months to prepare for and ensure HH self-efficacy in maintaining livelihoods to cover needs.</td>
</tr>
<tr>
<td>Low (Score: 8)</td>
<td>Families preparing to grow</td>
<td>Promotion (income growth)</td>
<td>Market linkages to prioritized value chains; access to business loans; skills training; connects to savings groups and employment opportunities/job creation through public-private partnerships and producer organizations.</td>
</tr>
<tr>
<td>Moderate (Score: 5–7)</td>
<td>Families working to make ends meet</td>
<td>Protection (asset growth and legal protection)</td>
<td>Connects to savings groups; group and individual business support; start-up/one-time grants; links to prioritized value chains; legal services for asset protection.</td>
</tr>
<tr>
<td>High (Score: 0–4)</td>
<td>Families unable to cover HH needs</td>
<td>Provision (consumption support)</td>
<td>Emergency funds/cash transfers; links to government of Kenya cash transfers and other social safety net programs.</td>
</tr>
</tbody>
</table>

Abbreviations: ES, economic strengthening; HH, household.
APPLYING A CONTINUOUS QUALITY IMPROVEMENT APPROACH TO ADDRESS STAGNATING OVC HOUSEHOLD GRADUATION

From October through December 2021, USAID Nuru Ya Mtoto’s OVC caseload comprised 37,367 HHs across Homa Bay, Kisii, and Migori counties, with 59% of enrolled HHs located in Homa Bay. The project observed a decline in HH graduation, with many HHs dropping out of the project’s OVC cohort without meeting all graduation benchmarks, and performance gaps in case management implementation. A cohort analysis and results from CPARAs conducted between October and December 2021 showed that 77% and 20% of HHs, respectively, had not met all required graduation benchmarks or dropped out without graduating (Figure 3). There were also many HHs that had “overstayed” or been in the project’s OVC cohort for more than five years—59% of HHs were enrolled for three or more years, as of January 2022.

A contributing factor to lower graduation rates and suboptimal outcomes for OVC HHs was limited stakeholder and systems support for integrated OVC service delivery, driven by weak community referral systems and unstructured stakeholder coordination mechanisms.

With 2,356 OVC having graduated as of December 2021 (52% achievement against the project’s annual target [4,518]), USAID Nuru Ya Mtoto embarked on an intensive continuous quality improvement (CQI) process in January and February 2022 to understand and address root causes driving low HH graduation rates and weak stakeholder coordination. USAID Nuru Ya Mtoto focused CQI efforts on Homa Bay County given its high OVC HH caseload, looking specifically at 477 HHs that had been enrolled in PEPFAR’s OVC program for more than ten years. This CQI effort entailed:

- Analysis of quantitative HH data gathered from annual CPARAs conducted with 298 HHs between 2019 and 2021 and an independent CPARA of a representative sample of project-supported OVC HHs, conducted by enumerators (instead of OVC case workers) in January 2022, to serve as an audit of annual CPARA results.
- Root cause analysis using data gathered through focus groups discussions with 40 OVC case workers and 60 caregivers to understand factors associated with HHs “overstaying” in OVC programming.
- Development of a corrective action plan informed by findings.

The process was overseen by an 18-member steering committee, comprising representatives from various GOK ministries and other key stakeholders, including the Directorate of Children

Figure 3: Distribution and outcomes of enrolled households, October–December 2021.
Services (DCS), Department of Health, Department of Gender and Social Protection, Ministry of Education, and private-sector partners (private provider networks and banks). The committee was co-chaired by the Regional Director of Children’s Services and the Chief Officer for Gender Services. USAID Nuru Ya Mtoto provided technical support throughout the CQI process, engaged data analysts, facilitated transportation to OVC HHs, and documented learning.

**ROOT CAUSES DRIVING STAGNATING HH GRADUATION**

**Graduation rates**

Analysis of CPARA results from 2019 through 2021 revealed dramatic fluctuations in HH vulnerability, instead of a clear progression of HHs along the graduation pathway, with very few HHs who met all criteria to graduate—only ten HHs in two years.

There was also a large discrepancy between the December 2021 CPARA (conducted by OVC case workers) and the January 2022 independent CPARA (conducted by non-project enumerators as part of the CQI process). The December 2021 CPARA results indicated that 73% of HHs were classified as moderate vulnerability, with only 1% ready to graduate, while the January 2022 CPARA results showed only 17% of HHs classified as moderate vulnerability, with 53% of HHs ready to graduate and none classified as highly vulnerable (Figure 4).

**Figure 4: Comparison of December 2021 and January 2022 CPARA results.**

![Comparison of December 2021 and January 2022 CPARA results](image)

Abbreviations: CPARA, case plan achievement and readiness assessment.

Results from the root cause analysis highlighted three main factors impacting low HH graduation achievement, long duration of enrollment in OVC programming, and discrepancies between CPARAs conducted by OVC case workers and independent enumerators:

- **False information provided by OVC caregivers**, driven by fear of losing access to services and program benefits if they graduate from the OVC program, desire for greater services and benefits by exaggerating their household vulnerability, low literacy levels and misunderstanding of questions being asked, cultural beliefs, self-insufficiency, and fear of stigma and discrimination.

- **False information provided by OVC case workers** due to the pressure they felt from community members who felt case workers were denying them continued program benefits or fear of case worker transition from the project due to “reduced” caseloads and/or saturation.
• **Inaccurate completion of CPARA and case plans** driven by two aspects: 1) negative case worker attitude toward the CPARA and case plan tools—case workers noted that the tools were too complex (both in language and concepts), bulky, and time-consuming to complete, which also led to instances of case workers completing tools themselves if HH caregivers did not have time to jointly complete the forms, and 2) perceived referrals by OVC case workers due to responses provided by caregivers.

• **Misunderstanding of graduation benchmarks**, specifically that children and adolescents who have achieved viral suppression and whose HHs met all graduation benchmarks are still not eligible for graduation as they are living with HIV.

**Stakeholder coordination**

The root cause analysis also revealed systems-level challenges that contributed to weak coordination and oversight structures, impeding provision of integrated and holistic services for enrolled HHs and further exacerbating stagnant graduation rates. These systems-level challenges include:

• **Poor referral completion leading to delayed service provision**: Suboptimal referral completion was driven by weak bi-directional referral mechanisms for following up with HH members (in cases of self-referral) or service providers (for inter-provider referrals) to verify referral completion. Limited community staff capacity and the use of numerous referral tools further exacerbated this situation.

• **Limited data sharing and analysis**: Lack of platforms for facility- and community-based providers, county/subcounty staff, implementers, and project staff to share data, analyze, and understand performance, and discuss actions to address performance gaps. This included suboptimal data reviews and sharing of feedback from implementing partners and LIPs to frontline staff (e.g., case workers).

• **Weak stakeholder coordination structures**: Lack of functional partnership mechanisms to support resource-sharing, moderate between competing organizational priorities, and outline roles and responsibilities. These weak coordination structures led to partners operating in silos instead of effectively coordinating to ensure the continuum of care for HHs.

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**OVC success in action: Holistic services leads to improved adherence and a safer future.**

Sarah, a woman living with HIV and a HH of four children, was struggling to adhere to her HIV treatment. She regularly missed clinic appointments, and adherence support measures were not successful. Sarah’s situation was further exacerbated when she lost her job at a construction site due to poor health. Her HH was flagged at a subcounty Quality Improvement Team meeting, with facility staff and USAID Nuru Ya Mto subsequently holding a HH case conference with Sarah. Socio-economic issues, driven by inadequate income, were jointly identified to be the root cause of several challenges she faced. Sarah enrolled in USAID Nuru Ya Mto’s “Watano Initiative,” where she and four other caregivers partnered to provide economic and psychosocial support to each other. She also received a business boost of 30,000 Kenyan shillings from the project to kickstart her agriculture business, participated in enhanced adherence sessions and positive parenting trainings, and joined a local women’s savings groups to further grow her business. This package of health, social protection, and economic strengthening services helped Sarah reclaim her life—she became adherent to her treatment, did not miss another clinic appointment, moved her family to a safer neighborhood, and became confident in her financial ability to provide education and food for her children, enabling her to create a more hopeful future for herself and her children.

“I could not fend for my children at all, and occasionally they would be fed by a next-door neighbor. [Now] I save 500–700 [Kenyan shillings] per week in our savings and loan group. I’m planning to build my own house when we share out.”
DEVELOPING A WHOLE -OF-SYSTEM SUITE OF INTERVENTIONS TO IMPROVE HH GRADUATION

Analyses revealed that the root causes driving stagnating HH graduation rates derived from challenges at multiple levels (HH, service-delivery, and systems), prompting USAID Nuru Ya Muto and involved stakeholders to apply a whole systems lens to develop a performance improvement plan. The performance improvement plan was jointly developed by the DCS, Department of Health, Department of Gender, private partners (Equity Bank, Postbank), OVC caregivers, OVC case workers, LIPs, and USAID. The performance improvement plan outlined key corrective measures, including outlining the need for revised or new tools, guidelines, and standard operating procedures; proposed a structured mentorship and supportive supervision plan (leading to development of a mentorship guide); and a partner coordination committee nested within County Children Advisory Councils. The final plan and updated OVC case management tools (revised by the United States Government OVC Technical Working Group) were adopted and implemented within six months and further scaled to four additional counties (Kisii, Migori, Nyamira, and Vihiga).

Leading with an OVC- and family-centered approach, corrective measures were implemented at the HH, service-delivery, and system levels (Figure 5) to address root causes driving stagnant graduation rates and weak stakeholder coordination. Efforts generally focused on facilitating timely identification and responses to HH needs; enhancing OVC case worker capacity through training, coaching, and structured supportive supervision; improving access to community support and social safety nets through strengthened referrals; streamlining and standardizing tools; and layering oversight and coordinating structures at multiple levels.

OVC success in action: Millicent’s story.

Millicent, who takes care of three children, one of whom is living with HIV, was enrolled in USAID Nuru Ya Muto’s OVC program in 2021. Millicent’s HH scored 7 out of 17 in her CPARA at enrollment. With emergency funds of 12,000 Kenyan shillings, she purchased a donkey to supply her village with water as an income-generating activity and later sold excess produce from her kitchen garden to further boost her income. Millicent also joined the village savings and loan association, which improved her financial literacy and provided access to capital to address immediate HH needs. She has since graduated from the project’s OVC program, and all members of her HH living with HIV are now virally suppressed.

A caregiver is provided with a sewing machine to support income generation to enhance their household economic resiliency. Photo: PATH/Denise Akun.

OVC case workers participating in a training session to understand the case plan achievement and readiness assessment (CPARA) tool in Homa Bay County. Photo: CARITAS Homa Bay.
Figure 5: Multilayered interventions to improve HH graduation rates.

Streamlined case management tools
- Streamlining CPARA guide/assessment, with pictorial job aids and benchmark summaries.
- Revising procedures to reinforce graduation pathway strategy co-creation.
- Creating a HH Benchmark Achievement and Graduation Tracker to monitor HH/OVC progress and service delivery per case plans.
- Creating a Children and Adolescents Living with HIV Validation Tool to track services provided to support viral suppression.
- Developing standardized referral tools and service directories to guide improved referrals.

Enhanced data sharing & use
- Intensified monthly tracking of service provision to OVC HHs at the project level, using data from the Child Protection Information Management System (CPIMS) to ensure progression along the graduation pathway and mitigate relapse.
- Holding monthly review meetings and quarterly learning exchanges to identify and address performance gaps while sharing best practices.
- Leveraging OVC data to advocate for increased stakeholder support and resources.

Improved stakeholder synergies
- Creating case worker–community trainer pairs to provide OVC services per established case plans.
- Clarifying county stakeholder roles, guided by the 2022 Children Act.
- Convening county-level monthly performance review meetings for work planning, monitoring, and supportive supervision.
- Increasing private-sector resource contributions for HH economic strengthening (e.g., start-up capital).

Strengthened OVC case worker capacity
- Assessing capacity-strengthening needs of and implementing individualized capacity-strengthening plans for 1,378 OVC case workers through practical/on-the-job training and mentorship.
- Holding bi-weekly supportive supervision and mentorship sessions led by CQI steering committee members.
- Coaching case workers to use a motivational approach during CPARAs and case-planning that capitalizes on HH strengths.
- Composing a Case Management Song as mnemonic device to improve case worker understanding of the full process.
- Reinforcing that viral suppression is not the sole determinant for HH graduation and that HIV-characterized HHs are eligible for graduation after meeting all social and economic benchmarks.

Optimized HH services & support
- Promoting mechanisms to provide ongoing access to savings and business capital (e.g., impact investments in dairy and agriculture income-generating activities; village savings and loans associations).
- Empowering OVC to participate in development of HH graduation strategies/case plans.
- Awareness-raising of government social safety net programs among HHs.
- Post-graduation monitoring by case workers to facilitate continued access and referrals to services for emerging HH needs.
- Equipping caregivers with coping mechanisms and strategies to better respond to emerging vulnerabilities and needs.
- Promoting graduated HHs as "graduation champions" to provide peer support.

Accurate HH case plans
- Reassessing 33,641 HH CPARA and case plans to accurately categorize vulnerability and be responsive to current HH needs.
- Ensuring updated records in CPIMS to enable OVC partners to extract and use accurate data to guide OVC service provision.
- Conducting routine, structured, random visits by LIPs and implementing partner leadership teams to HHs for increased transparency and accountability of service delivery to OVC HHs.
IMPACT AND WAY FORWARD

The implementation of interventions at household, service-delivery, and system level led to gradual improvements in HH graduation rates throughout the year, with a cumulative 4,088 HHs and 9,037 OVC graduating between October 2021 and September 2022, with the number of OVC graduating doubling the project’s annual graduation target (Figure 6). The number of HH exits before graduation also decreased dramatically, with only 298 HHs dropping from the program between July and September 2022 (Figure 7), compared to 9,630 between October and December 2021, representing a 32-fold decrease.

USAID Nuru Ya Mtoto continues to work with county leadership and stakeholders at multiple levels to sustain this multidisciplinary approach (as outlined in Figure 5) to support OVC HHs enhance their resiliency and help them graduate from PEPFAR’s OVC program. The project maintains on-site briefings and structured supportive supervision to enhance OVC case worker capacity, reinforce consistent use of updated case management guidance and standardized referral tools, and encourage buy-in of new interventions. To allay OVC case worker job loss concerns and attrition, USAID Nuru Ya Mtoto actively works to ensure each case worker has a caseload of 60 OVC across 15–20 HHs, enabling them to maintain a full roster without overburden or impacting service quality. OVC case workers were also provided with a monthly stipend and embedded in the county government’s community structure for longer-term sustainability. The project also continues to strengthen LIP capacity to oversee OVC service provision—including leveraging the Child Protection Information Management System to regularly access disaggregated data to understand performance across four OVC program components and deploy corrective actions as part of ongoing CQI efforts—while supporting LIP resource mobilization efforts by helping to secure partnerships or assisting with proposal development.

A key learning from this effort has been the need for strong county-led and -owned mechanisms to ensure effective coordination across all involved stakeholders (government agencies, implementers, private-sector partners). This learning has led to empowering and charging the partner coordination committee embedded within County Children Advisory Councils with the responsibility of overseeing OVC service delivery, with the committee meeting quarterly to provide critical direction on provision of multidisciplinary services for OVC and their HHs and recommend policy revisions.

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