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Situational analysis of Orphans and Vulnerable Children in urban and rural communities of Plateau State

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Abstract

Background: Orphans and Vulnerable Children (OVC) are children affected by HIV and AIDS by virtue of, among others, living in a household where one or more people are ill, dying or deceased, or which fosters orphans, and children whose care givers are too ill or old to continue to care for them. They often have more health needs than their peers. This study was carried out to obtain baseline information on the needs of OVC in North-Central Nigeria as a basis for provision of relief services.

Methods: A house to house cross-sectional survey of OVC recruited via a multistage sampling technique was carried out in four LGAs of Plateau State, Nigeria. The Child Status Index (CSI) tool was used to obtain information from the respondents and/or their caregivers. Vulnerability of the children was assessed using a Vulnerability Index (VI) scoring which ranged from 1-21, with 1-9 being vulnerable, 10-14 more vulnerable, and 15-21 being most vulnerable.

Results: A total of 825 OVC ages ranging from 0-17 years and mean age of 9.8 ± 4.5 years were studied. 432 were males (52.4%) and 393 females (47.6%). 64.8% lived in households headed by women out of which 77.6% were widows. Six hundred and one (72.8%) household heads were farmers. Paternal orphans made up 59.8% of the respondents and 12.1% had lost both parents. Prevalence of abuse/exploitation was 17.7% and 66.7% experienced household food insecurity. Four hundred and seventy-eight (57.9%) OVC lived in households with no source of income. One hundred and fifty-one (18.3%) children (54.9% boys and 45.1% girls) had never been to school. 55.0% had minimal health problems. Majority of them (60.3%) lived in dilapidated shelter and 3.3% were living on the street.

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

Keywords: Child status index, educational needs, orphans and vulnerable children

Résumé

Contexte: Orphelins et enfants vulnérables (OEV) sont des enfants touchés par le VIH / sida en vertu de, entre autres, vivant dans un ménage où une ou plusieurs personnes sont malades, mourants ou décédés ou qui favorise des orphelins et enfants dont soignants sont trop malades ou trop vieux pour continuer à prendre soin d'eux. Ils ont souvent des besoins de santé plus que leurs pairs. Cette étude a été réalisée pour obtenir des renseignements de base sur les besoins des OEV dans le centre-nord du Nigeria comme base pour la fourniture de services de secours.

Méthodes: Une étude transversale de maison en maison des OEV recruté via une technique d'échantillonnage à plusieurs étapes a été réalisée en quatre LGAs de Plateau State, Nigeria. Outil the Child Status Index (CSI) a été utilisé pour obtenir des informations auprès des intimées ou de leurs soignants. Vulnérabilité des enfants a été évaluée à l'aide d'un Index de vulnérabilité (VI) marquant qui variait de 1-21, 1-9 étant vulnérable, plus vulnérables 10-14 et 15-21 étant plus vulnérables.

Résultats: Un total de 825 OVC âges allant de 0 à 17 ans et l'âge moyen de $9,8 \pm 4,5$ ans ont été étudiés. 432 étaient

de sexe masculin (52,4 %) et les 393 femmes (47,6 %). 64,8 % vivaient dans des ménages dirigés par des femmes, dont 77,6 % étaient des veuves. Six cent onze chefs de ménage (72,8 %) étaient des fermiers. Orphelins paternelles composés de 59,8 % des personnes interrogées et 12,1 % avaient perdu leurs deux parents. Prévalence de la violence ou d'exploitation était de 17,7 % et l'insécurité alimentaire des ménages 66,7 % ont connu. Quatre cents et soixante-dix-huit (57,9 %) OVC vivaient dans des ménages sans aucune source de revenu. Cent et cinquante et un (18,3 %) enfants (54,9 % de garçons et 45,1 % de filles) n'avaient jamais été à l'école. 55,0 % avaient des problèmes de santé minimale. Majorité d'entre eux (60,3 %) vivait dans des abris vétustes et 3,3 % vivaient dans la rue.

Conclusion: Cette étude a révélé les différents besoins des OEV. Efforts pour les soins, de soutenir et de protéger les enfants vulnérables ne devraient pas se concentrer seulement sur leurs besoins de survie immédiate tels que l'éducation, les abris et les vêtements, mais aussi sur les besoins de développement à long terme qui réduisent la vulnérabilité des enfants tels que les compétences de vie, protection de l'enfance, formation professionnelle, la sécurité alimentaire et renforcement économique domestique.

Mots-clés : Index de statut enfant, l'éducation doit, orphelins et enfants vulnérables

Introduction

The number of children made orphan and vulnerable by the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) epidemic in Plateau State has been on the rise in spite of efforts aimed at combating the disease. Also contributing to this growing number of orphans are the numerous children who have lost one or both parents in various ethno-religious crises in the state. An orphan is defined by the Joint United Nations Program on HIV/AIDS (UNAIDS) as a child under 18 years of age whose mother (maternal orphan), father (paternal orphan), or both parents (DO) have died as a result of HIV.^[1] The Nigerian constitution defines an orphan as a child (0-17 years) who has lost one or both parents.^[2] A child is vulnerable if, because of the circumstances of birth or immediate environment, is prone to abuse or deprivation of basic needs, care and protection and thus disadvantaged relative to his or her peers.^[2] Orphans and Vulnerable Children (OVC) are children affected by HIV and AIDS by virtue of, among others, living in a household where one or more people are ill, dying, or deceased, or which fosters orphans, and children whose caregivers are too ill or old to continue to care for them.^[2]

A child made vulnerable by AIDS is below the age of 18 and has lost one or both parents, or has a chronically ill parent (regardless of whether the parent lives in the same household as the child), or lives in a household where in the past 12 months at least, one adult died and was sick for 3 of the 12 months before he/she died, or lives in a household where at least one adult was seriously ill for at least 3 months in the past 12 months, or lives in a child-headed household or lives outside of family care (i.e. lives in an institution or on the streets).^[3] Other factors responsible for vulnerability include repeated ethno-religious conflicts, maternal mortality, and gender inequality.

HIV and AIDS has negatively impacted the development of communities affected by it, as it continues to devastate individuals, families, and households, affecting their physical, social, psychological, and economic well-being. Globally, more than 16 million children have been made orphans as a result of AIDS with more than 2.5 million of them living in Nigeria.^[4,5] It is reported that approximately 25% of an estimated 70 million children in Nigeria can be characterized as vulnerable.^[2] This burden of OVC is higher than countries facing war, such as Sudan, Somalia, Democratic Republic of the Congo, Libya, and Syria. One in every 10 households in the country is also estimated to be providing care for an orphan. Estimates also indicate that out of the over 1.3 million children in Plateau State, about 160,000 (12.3%) are orphans, 40,000 of which are due to AIDS.^[6] These children are more prone to ill health than children in more secure circumstances, have less access to health care and miss meals more frequently, and are more likely to skip school, or not go to school at all.

Parental death can affect various aspects of a growing child's development. The loss of a father or mother can result in loss of shelter, school drop-out or non-enrolment in school, poor health outcomes, malnutrition, abuse and stigmatization. The effect of parental death on education is likely to vary as previous studies have shown.^[7] School enrolment rates in the country are already low, often below 50%.^[8] When a parent dies, older children may be expected to take up paid employment and care for younger siblings. The ability of bereaved children to continue in school depends on households' resources and the public support for education.^[9] Surveys carried out among orphans in Uganda and Malawi showed that they were more likely to have higher school absenteeism rates than non-orphans.^[10]

In a study carried out among children in Zimbabwe, OVC were found to be more likely

than non-orphans to have recently suffered from diarrheal disease and acute respiratory infections and they were also more likely to be stunted.^[11] Girls were found to be especially vulnerable to sexually transmitted infections, including through greater physiological susceptibility.^[12] Loss of parent (s) can affect the psychological and physical development of a child and older children above 15 years may experience sexual and economic exploitation.^[13]

Minority status, disability, and residence in under-served areas can also make children vulnerable. The youngest children are the most vulnerable over the long-term because their bodies, brains, social relations, and self-confidence develop rapidly during early childhood. Any interruptions and delays in young children's developmental potential are difficult to recover in later years, especially when children continue to live under difficult conditions. Young children need good nutrition, care, and encouragement from stable caregivers, as well as opportunities to learn, protection from harm, and preventive health care. Community-based early childhood development activities can provide such support and care, especially when parents are also engaged in livelihood activities.

In many settings, adolescent girls face a risk of sexual violence and rape, both inside and outside of marriage, due to gender disparities and sexual and social norms. They also carry a large burden of care. While adolescents share the same needs for housing, food, social support, and education as their younger counterparts, they face key developmental steps which may be particularly challenging for those who are vulnerable. Community programs, peer education, and health services addressing the needs of vulnerable adolescents should be delivered through sex- and age-appropriate interventions aimed at increasing support and reducing risk.

This study was carried out to obtain baseline information on the specific needs of OVC in Plateau State, North-Central Nigeria as a basis for provision of relief services in line with the National Plan of Action for OVC Care in Nigeria.

Materials and Methods

Study area

The study was carried out in four local government areas (LGAs) of Plateau State namely Jos South, Mangu, Riyom, and Bassa LGAs. Jos South and Mangu are mainly urban while Bassa and Riyom are predominantly rural LGAs.

Study design

The study was a cross-sectional descriptive survey to assess the socio-demographic characteristics and needs of OVC in the selected communities.

Study population

This consisted of OVC aged between 0-17 years living in the LGAs under study. Orphan hood was defined as a child that had lost one and/or both parents. A vulnerable child was defined as one below the age of 18 and: Has a chronically ill parent (regardless of whether the parent lives in the same household as the child), or lives in a household where in the past 12 months at least one adult died and was sick for 3 of the 12 months before he/she died, or lives in a household where at least one adult was seriously ill for at least 3 months in the past 12 months, or lives in a child-headed household, or lives outside of family care (i.e. lives in an institution or on the streets), or is living with HIV and AIDS. Respondents consisted of parents and caregivers for the younger OVC while information was obtained directly from the older OVC.

Sample size determination

The minimum sample size was calculated using the standard acceptable formula^[14]

$$n = \frac{z^2 pq}{d^2}$$

$$z = 1.96$$

$$P = 0.12 \text{ (proportion of children who are OVC in Plateau State)}^{[6]}$$

$$q = 1-P$$

$$d = 0.05$$

$$n = 162 \text{ OVC per LGA}$$

Sampling technique

Multistage sampling technique was used to select the respondents.

Stage one

The 17 LGAs in the state were stratified into urban and rural LGAs from which two LGAs each were selected by simple random sampling by balloting. Jos North and Mangu LGAs were selected from the urban LGAs while Bassa and Riyom LGAs were selected from the rural LGAs.

Stage two

In each LGA, three communities were selected using simple random sampling technique by balloting making a total of 12 communities.

Stage three

With the help of trained volunteers, all households in each selected community were numbered and

systematic sampling was used to select a minimum of 54 OVC per community. In every household visited, OVC were identified based on the definition of an OVC.

Data collection instrument

The Child Status Index (CSI) tool was adapted and used to obtain information from the respondents and/or their caregivers. This is a tool designed for use in countries with low literacy rates where community caregivers are providing care and support services to OVC.^[15] It is interviewer-administered and it assesses the child's socio-demographic and vulnerability status covering six thematic areas of health, nutrition, shelter, protection, education, and economic status of households.

Data collection protocol

A 1-day training on data collection was held for the research team which consisted of two Community Health Extension Workers (CHEW) and two sociologists.

Ethical considerations

Permission was sought and obtained from the Plateau State Ministry of Women Affairs which is the parastatal responsible for OVC care in the state. The Directors of Primary Health Center (PHC) in all the four LGAs as well as village heads of all the communities involved in the survey were also informed about the study. Verbal consent was sought and obtained from the respondents and/or their caregivers. Anonymity and confidentiality of all information obtained from the respondents was assured and maintained.

Data analysis

Data collected was analyzed using EPI Info version 3.5.4 software. Public Domain Statistical Software for Epidemiology developed by the Centers for Disease Control and Prevention (CDC), Atlanta, Georgia, USA.

Scoring

Each of the thematic areas was graded based on the rating below:

Health

- 0 No health constraint
- 1 Good health with minimal sickness
- 2 Frequently sick with access to health care
- 3 Frequently sick with no access to health care
- 4 HIV+ with chronic illness.

Education

- 0 No educational constraint
- 1 Irregular school attendance

- 2 Drop-out from school
- 3 Never attended school.

Shelter

- 0 No shelter and care constraint
- 1 Overcrowded home
- 2 Dilapidated shelter
- 3 No shelter (living on the street).

Protection

- 0 No protection constraint
- 1 At risk of abuse
- 2 Requires social protection
- 3 Has experienced abuse or exploitation.

Nutrition

- 0 No nutritional constraint
- 1 Child shows weight loss compared with age-group in the community
- 2 Child shows weight loss compared with age-group in the community and is ill
- 3 Child shows serious weight loss and is chronically ill
- 4 Household food insecurity.

Household economic strengthening

- 0 No economic constraint in child's household
- 1 Caregiver with low income level
- 2 Caregiver with no income-generating skills
- 3 Child providing income for the household
- 4 No source of income for the household.

Vulnerability was then assessed after summing up the scores for all the thematic areas as follows:

Vulnerability Status	Grade
Most Vulnerable	15–21
More Vulnerable	10–14
Vulnerable	1–9

Results

A total of 825 OVC, with ages ranging from 0-17 years and mean age of 9.8 ± 4.5 years were studied. Three hundred and seventy-one (45%) were aged between 0-9 years while 454 (55%) were aged 10-18 years. There were 432 males (52.4%) and 393 females (47.6%). Majority of them 535 (64.8%) lived in households headed by women out of which 426 (79.6%) were widows. Six hundred and one (72.8%) household heads were farmers. Paternal orphans made up 59.8% of the respondents and 100 (12.1%) children had lost both parents. One hundred and fifty-one (18.3%) children (54.9% boys and 45.1% girls) had never been to school while 88 (10.7%) of them were presently out of school. HIV prevalence was 1.1% among the respondents. However, 712 (86.4%) of them did not know their HIV status [Table 1].

Four hundred and fifty-three OVC (55.0%) had minimal health problems (0-1 health score). Majority of them 497 (60.3%) lived in dilapidated shelter and 27 (3.3%) were living on the street. Prevalence of abuse/exploitation was 17.7% and 550 (66.7%) experienced household food insecurity. Four hundred and seventy-eight (57.9%) OVC lived in households with no source of income [Table 2].

Three hundred and sixty-eight children (44.7%) had a VI score of 10-14 and 285 (34.5%) were assessed to be most vulnerable with a VI score of 15-21 [Table 3].

Sex was not statistically significantly associated with VI score ($P = 0.6962$), nutritional status ($P = 0.9667$), educational status ($P = 0.5298$) or health status ($P = 0.2284$).

Table 1: Socio-demographic characteristics of orphans and vulnerable children

Variable	Frequency	Percentage
Age of child		
0-9	371	45.0
10-17	454	55.0
Sex		
Male	432	52.4
Female	393	47.6
OVC status of child		
Paternal orphans	493	59.8
Vulnerable	179	21.7
Double orphans	100	12.1
Maternal orphans	53	6.4
Marital status of household head		
Widowed	426	51.6
Married	332	40.2
Single	60	7.3
Seperated/divorced	7	0.9
Occupation of household head		
Farming	601	72.8
Housewife	84	10.8
Trading	70	8.5
Teaching	17	2.1
Schooling	11	1.3
Others	42	5.1
HIV status		
Positive	9	1.1
Nega	104	12.6
Unknown	712	86.4

HIV=Human immunodeficiency virus, OVC=Orphans and vulnerable children

Table 2: Needs/problems of orphans and vulnerable children

Score	0 (%)	1 (%)	2 (%)	3 (%)	4 (%)	Total
Thematic area						
Health	53 (6.4)	400 (48.6)	145 (17.6)	216 (26.2)	11 (1.3)	825
Education	63 (7.6)	523 (63.4)	88 (10.7)	151 (18.3)	-	825
Shelter	53 (6.4)	247 (30.0)	497 (60.3)	28 (3.4)	-	825
Protection	95 (11.5)	174 (21.1)	410 (49.7)	146 (17.7)	-	825
Nutrition	48 (5.8)	116 (14.1)	79 (9.6)	32 (3.9)	550 (66.7)	825
Household economic strengthening	5 (0.6)	185 (22.4)	132 (16.0)	25 (3.0)	478 (57.9)	825

Discussion

Available demographic data on orphans and vulnerable children in the state has shown that their numbers are on the increase in spite of efforts aimed at controlling the AIDS epidemic. This study revealed that the highest proportion of OVC was for paternal orphans which made up 59.8% of the respondents followed by vulnerable children 21.7%, 12.1% children had lost both parents and maternal orphans 6.4%. This is similar to the situation in South Africa where majority of the orphans had lost fathers.^[10] The large proportion of children without a father in this study is at first surprising, considering the fact that the HIV prevalence among women is higher than among men in the state and even in Nigeria generally. It is, however, a common finding that fathers are on average older than mothers, and young adult men have higher non-AIDS age-specific mortality rates than young adult women.^[16]

This survey revealed that one of the main problems of OVC was poor shelter. Only 6.4% of the respondents had no shelter constraints compared with 60.3% of them who were found to be living in dilapidated shelter. Even though only a small percentage of the OVC (3.3%) studied were found to be living on the street, the lack of shelter could predispose them to other social problems such as exploitation and abuse. This is similar to findings from a situational analysis of needs of OVC in South Africa where one of their major problems was found to be lack of adequate shelter.^[10]

Parental death has been shown to affect the schooling status of children. This study revealed that 18.3% of the children studied had never been to school while 10.7% of them had dropped out of school. A major reason for dropping out of school

Table 3: Vulnerability assessment of orphans and vulnerable children

VI score	VI status	Frequency	Percentage
1-9	Vulnerable	172	20.8
10-14	More vulnerable	368	44.7
15-21	Most vulnerable	285	34.5
Total		825	100

was inability to pay school fees. Among those in school, majority (89%) of them had irregular school attendance as a result of non-payment of school fees, lack of school uniforms and other reasons. These findings are similar to that of the studies carried out in Uganda and Malawi which revealed that orphans were more likely to have higher school absenteeism rates than non-orphans.^[8,10,11] This is however different from the situation of OVC in EkondoTiti, Cameroon where most of the OVC studied there were found to be in school.^[17]

Only 6.4% of the children studied in this survey had no health constraints at the time of the study. Almost half of them (48.6%) were found to be in good health with minimal sickness. This is quite encouraging but this finding is different from the findings of the health status of OVC in Cameroon which revealed that 90% of them had one health problem or the other while another study carried out among children in Zimbabwe showed that OVC were more likely than non-orphans to have recently suffered from diarrheal disease and acute respiratory infections and they were also more likely to be stunted.^[9,12] More worrisome in this study however, is that 26.2% of the OVC were found to be frequently sick and were without access to healthcare. The lack of access to health services could worsen their already vulnerable situation.

Prevalence of abuse/exploitation was 17.7% among the OVC studied. This is not surprising since it is on record that in Nigeria, girls aged 12-17 years are regularly trafficked from villages and brought to the cities to work as maids for an average monthly wage of 1,500 naira which they usually send back to their grandparents who are caring for several of their siblings. Some of these girls most times are not paid. This has become very important given that most trafficked victims are mostly orphans and other vulnerable children. Apart from being denied access to education, these girls are in many cases raped and beaten by their employers. As well as poverty, trafficking in girls and orphaned children is driven by the extreme income inequality which exists in Nigeria as well as gender inequality.^[2]

Childhood malnutrition is one of the major causes of childhood morbidity and mortality in Nigeria and this study revealed that more than a quarter of the children studied showed symptoms of mild to moderate malnutrition such as weight loss. Even worse, 66.7% of them were experiencing household food insecurity putting more of them at risk of malnutrition. This finding is not surprising since more than half of the respondents (57.9%) lived in households with no source of income apart from subsistent farming. This situation is similar to that of OVC in Cameroon

where more than a third of the OVC families needed income-generating activities to support the children.^[16]

Conclusion and Recommendations

This survey revealed the numerous challenges facing OVC in areas of education, shelter, health, protection and nutrition. Findings also showed that most of the OVC are cared for by mainly widowed subsistent farmers. Efforts to care, support and protect vulnerable children should not only focus on their immediate survival needs such as food, education, water, shelter and clothing, but also on long-term developmental needs that reduce children's vulnerability such as life skills, child protection, vocational training, food security, and household economic strengthening.

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