

## **Exploring Psychological Disorders Caused By Poverty amongst Orphans and Vulnerable Children Living Within Child – Headed Households**

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### **ABSTRACT**

Orphanhood and vulnerability are two variables found to be positively correlated to poverty within child- headed households (CHH) in Zimbabwe. Whilst the Zimbabwean Millennium Goal number 1 aims to eradicate poverty and hunger by 2015, some orphans and vulnerable children (OVC) within CHHs continue to face psychological challenges perpetuated by the ever- rising poverty datum line, that seem to be leading victims to psychological disorders . Arguing from a humanistic point of view, this survey examined the psychological disorders noted among OVC by community caregivers and teachers in Chipinge District of Manicaland in Zimbabwe. A total sample of 20 OVC, were purposefully and clinically sampled, observed initially in their natural settings and later on interviewed to solicit data on their developmental experiences. The study also presents a detailed account of the manifestations of resultant psychological disorders most of which were found to be rooted in poverty and need deprivation amongst the majority of the OVC. The children lack sufficient resources to sustain family life. Findings of this survey confirmed that OVC in CHH are faced with psychological difficulties that are somehow leading to the mushrooming of symptoms of psychological disorders such as dissociative, affective, anxiety and somatoform disorders. The implication of such situations amongst children, is that communities need to make collaborative efforts to assist all OVC to live a more or less normalized family life within their poverty stricken CHHs.

**Key words:** Orphans, Poverty and Psychological Disorders.

### **BACKGROUND**

According to WHO (1990), cited by GDD Plan Finland (2005), the phenomenon described as “ child headed” was first noted in the 1980s in Rakai District of Uganda. Early researchers, such as Foster (2002) had assumed there was no such thing as “child headed” in Africa because culturally orphaned children were naturally looked after within households of their extended families which acted as social security systems for orphans and other vulnerable groups. Today, there seem to be a paradigm shift because most extended families are unable to cope with the ravaging poverty and extra responsibilities. Ideas on how to mitigate and support orphans has become a major concern for the international community (Ennew, 2005). The rights based approach to child welfare, initiated by the United Nations Convention on the Rights of the Child, has been found to be supportive and augers well the plight of orphans and vulnerable children (OVC).

Orphan hood is rather regarded as acute poverty for it deprives the child of an immediate caregiver hence the need to erect child-headed household (CHH) as a coping mechanism by children faced with orphan crisis. According to UNAIDS (2004), Africa has 14 million orphans and it is estimated that the figure might rise to 50 million by 2015. It has been observed that local orphans are usually sent to members of the extended families where they fail to fit and finally resort to CHH. This is because most of the time the orphans are turned to unpaid laborers and home nurses for the terminally ill within the extended families. They may even stop going to school making them poorer in both education and material resources. In the newer homes, orphans receive different levels of treatment where they are somehow excluded from most profitable family activities (Chirwa, 2000, Nyambedha et al , 2003 and Oleke et al, 2006).

Nyamukapa and Gregson (2005) contend that besides social discrimination, orphans face a high risk of contracting HIV and AIDS which has very high risks that lead most victims to even lower socio-economic status (SES) than before. HIV and AIDS is an exceptional cause of orphan hood and vulnerability in that if a parent is infected with HIV, the probability that the spouse is also infected is very high meaning that children remain at a high risk of becoming double orphans within shorter periods (Monk, 2001). In concurrence, UNAIDS, UNICEF and USAIDS (2004) claims that by 1990 and 2001 the proportion of orphans whose parents died of HIV and AIDS rose from 3.5% to 32%.

The UN Childrens Fund cited by Schelein Report (2007) claims that Zimbabwean children are suffering from orphan crisis that is depriving them of a chance for education and good health. Personaz of UNICEF (2007) also declares that within a population of 15 million, 12 million people are vulnerable children. UNICEF reiterates the fact that one in every four children is an orphan. Even though the prevalence dropped due to “Behavior change” intervention programs countrywide, the number of orphans in poverty remains the same. The level of poverty is worsened by the failure to complete school as compared to non-orphans (Nyamukapa and Gregson, 2005).

Abebe (2009) revealed that there is a strong correlation between endemic poverty, child destitution and orphan hood. He also postulates that one (1) in every three (3) children in African countries is poor and malnourished. The number of hungry children is also rising. Africa is claimed to have a large number of very poor children. The United Nations (2002) confirms that 40% of the child’s population does not attend school. More than 50% does not have safe drinking water or primary health care services. Plessis and Conley (2007) add on to confirm the poverty levels saying the prevalence of preventable diseases is increasing and unemployment is rather chronic. This leaves children in distressful predicaments which is rather worse in situations of orphan hood. Orphan hood leads to vulnerability.

Most of the huddles faced by orphans are poverty related. These range from situations of lack of food, education, medical care, sanitation facilities, urbanization – monetarization and globalization – driven social inequalities (Hunter, 1990; Therbon, 2004; Meintjes and Bray, 2006 and Abebe, 2008). All these situations heavily impact on the children leaving more harm on the parentless child. Bass (2004) and Abebe and Aase (2007) contend that some economic and political transformations such as debt, corruption, war, political conflicts, epidemics , unfair trade, structural adjustment programs (SAP) and ineffective legislation affect OVC in multifaceted ways.

Abebe (2009) claims that, in times of poverty, work is often shifted to women who then share it with the children. The situation is rather unbearable in CHH where there is no mother to whom burdens may be shifted. Instead, the older girl child in most cases takes the role of the mother. On the other hand, the boy child struggles to make ends meet in all efforts to resemble the head of the family within the CHH. All in all, these traumas usually lead to psychological or psychosocial problems throughout the life of the OVC. Poverty is not only an economic matter but also a matter that deprives OVC and many other individuals and communities of their desired satisfaction in terms of their social and psychosocial, political, physical, spiritual and economic well being. It has been noted that poverty is causing some difficulties in the lives of children who opt to reside on their own after the death of both parents. The older child may stop school and become the main bread winner by continuing to work on farms whilst the younger siblings struggle to remain in school.

This study endeavored to investigate some of the psychological challenges emanating from extreme poverty amongst OVC residing in CHH of Chipinge District farm compounds in Manicaland, Zimbabwe. Even though the Zimbabwean Millennium Development Goal (MDG) number 1 aims to eradicate poverty and hunger by 2015, some OVC within CHH continue to be faced with a lot of psychological challenges that are somehow perpetuated by the ever rising Total Consumption Poverty Line (TCPL) or Poverty Datum Line (PDL) for most people in Zimbabwe.

## **THEORETICAL FRAMEWORK**

This study is basically informed by humanists in the sense that it honours the fact that every human being, including the OVC has the right to dignified living. Both humanists, Abraham Maslow and Carl Rodgers, share a strong belief in self-determination and individual potential. They believe that all people are free to become what they want, to fulfill themselves and to curve their own destinies. In essence the two concur on the individual's need for self-actualisation through gratification of various hierarchical needs (Maslow, 1987). On the other hand Rodgers (1971) presents the need for self worth and positive regard within one's phenomenal field.

Failure to attain one's best stance in life may result in multiple stressors that may make life a living burden for some individuals. Failure to self-actualize is caused by multiple possibilities that include various forms of poverty. Some children, previously born in ravaging poverty, may continue to survive in even more ravaging poverty. When their parents die they carry the burden of poverty in orphan hood leading to severe vulnerability, hence the term orphans and vulnerable children (OVC).

Rutter's Pathway Model (Rutter, 1976) endeavors to explain that children born in poverty can have self-writing tendencies, making them much more resilient to pressures of poverty. On the other hand, De Lones Situational Theory expresses the fact that children do survive in overlapping settings or circles hence we find that once born of poor parents, then one may become poorer especially if orphaned. Because of the self writing tendencies, some children end up believing that they are to remain poor and so can be accustomed to poverty and live with it. However, if somebody comes and throws the lifeline, then the path can change to positive outcomes. There is, therefore a possibility of OVC becoming rich if capacitated.

The socio-cultural perspective, argues that the roots of mental disturbances often lie in social ills such as poverty .Research has established that the higher rate of serious mental disorders such as schizophrenia and alcoholism are amongst the lowest socio-economic groups or the poor (Redlich and Kellert, 1978). Therefore, children born and orphaned in poor families often remain poorer up to their very end. The poorer one is, the more vulnerable one becomes, leading to life stresses and eventually some multiple psychological disorders that are detrimental to one's well being.The lives of poor people are generally more stressful than those of higher SES. Pearlin and Schooler (1978) have also added that the poor seem to be ill prepared to cope with various life stresses emanating from poverty, leading to some psychological disorders, that may need treatment. Poor orphaned children are children in distress because they are covered in an umbrella of a number of psychological traumas that may lead them to psychological disorders.

### **The Purpose of the Study**

This study was meant to alert all stakeholder communities on some of the psychological challenges observed amongst OVC emanating from extreme poverty in CHH. It endeavors to describe the situation in both qualitative and quantitative terms. Extreme poverty is actually leading some OVC in CHH to extreme distress and depression that necessitates intervention by all able citizens of Zimbabwe.

Most of these situations are usually noted by community caregivers and the teachers of those OVC who might be lucky to continue with school. This study tries to bring awareness to the people of Zimbabwe on the observed psychological disorders that seem to be on the increase amongst the OVC living within CHH. Perhaps if these psychological cases are noted then early intervention by the Ministry of Health and Child Welfare and others could be identified and implemented early enough. The findings of this study in Chipinge District can also be the basis to check on prevalence and effects of the psychological disorders in other districts and provinces countrywide. Good psychological health is evidenced by resilience which may not be evident in OVC in CHH due to the effects of uncontrollable poverty.

### **Major research question**

How do psychological problems manifest amongst OVC living within CHH in farming compounds of Chipinge District?

#### **Sub-problems**

- a) What are the developmental experiences encountered by OVC within the poverty stricken CHH?
- b) Do poor OVC portray signs and symptoms of psychological disorders?
- c) Which psychological disorders are manifested amongst OVC in CHH?

### **METHODOLOGY:**

#### **Research Design**

This study adopted a descriptive survey in order to explore and present an authentic OVC poverty situation within CHH and the resultant types of psychological disorders observed in farming compounds of Chipinge District.

## **Sampling**

Twenty (20) OVC residing in CHH were randomly selected from a total of 80 OVC noted and observed over 6 months in four farming compounds of Chipinge District. Poverty levels of the OVC were deduced from local details of what the orphans owned, what they fed on, their sources of income, their general status of need fulfillment and extent of help obtained from well wishers. An equal number of boys and girls, aged between 10 and 18 years, were ensured at 50% on each gender representation. Ten (10) teachers were also randomly selected to assist with observations. Ten (10) community caregivers were also interviewed to give a more authentic picture to the poverty situation within CHH.

All teachers sampled had either a certificate or a diploma in education. Amongst the ten community caregivers were four purposely selected nurses who assisted in confirming some of the noted psychological disorders. The total sample came up to forty (40) participants made up of 20 OVC, 10 teachers and 10 community caregivers.

## **Instrumentation**

Effects of poverty were noted through an observation guide developed for use by teachers and nurses to check frequencies on the signs and symptoms of various psychological disorders amongst orphans. The four major groups observed were: somatoform disorders, dissociative disorders and affective disorders (Wortman and Loftus, 1988). Community caregivers responded to an interview guide that determined developmental deprivation amongst OVC due to effects of poverty. The twenty OVC also responded to interviews in order to solicit data on OVC's developmental experiences in poverty stricken living conditions. Interviewing also enabled manifestation of some psychological disorders as interaction took place between OVC and researchers.

## **Ethical Considerations**

The researchers were aware that every person, including the OVC, has the right to dignity of treatment and privacy. It was therefore vital to explain the purpose of the study to participants. The major aim of the study was to establish the state of poverty within CHH and the types of psychological disorders caused by the condition the OVC reside in.

The researchers were also aware that the whole process of research could have more psychological effects on the OVC and so interviews were interjected by some psychosocial counseling during visits to households. Only pseudo names were to appear in the findings in order to preserve personal dignity of participants. Data collected was to be used for educational research purposes and perhaps to establish avenues to assist OVC in dire need to eradicate effects of poverty in their development.

## **THE RESULTS**

### **Demographic details of Participants**

This section reports specific demographic details of the 20 selected OVC and findings from observations and interviews held at the four farm compounds in Chipinge District. It was necessary to begin from a clear presentation of the age ranges and gender of selected orphans in order to magnify exactly how far poverty goes in disorganizing the living conditions and adding on to other stressors on children living in orphan hood.

**Table 1: Distribution of OVC by Age and Gender; n =20**

Age Ranges (years)	Gender		Frequency (f)	%
	Girls	Boys		
8 - 10	2	2	4	20
11 – 13	4	4	8	40
14 – 16	3	3	6	30
17 – 18	1	1	2	10
Totals	10	10	20	100

The greater number of OVC selected fell between the 11 – 13 year age group. The tabulated data also implies no gender bias in as far as gender representation is concerned. The younger orphans attended primary and secondary school whilst the older ones, from 16 – 18 years, worked on the farms in order to earn some money for looking after themselves and their siblings within the CHH.

Of the 20 caregivers and teachers selected, ages ranged between 36 and 55 years. More females (60%) participated in the study than males (40%). The slight deviation respected Gilligan’s (1982) view that women are much more caring than men, hence the need for having more of women as caregivers. Among the 20 caregivers four nurses were selected to help confirm the noted psychological disorders amongst OVC.

### **The Orphans and Vulnerable Children’s Voices**

The next set of data narrates interview responses from the 20 selected OVC on their developmental experiences within their poverty stricken CHH. The children gave the following major challenges:

- Hunger, stress and exposure to disease e.g. HIV and AIDS
- Insufficient and indecent clothing and bed linen
- Indecent shelter with leaking roofs
- Insufficient school fees
- Unbearable communal sanitary facilities
- Destitution
- Overworking and fatigue
- Challenges on care of sick and younger siblings
- Stigmatization
- Lack of adequate security

A more interesting but disturbing finding was where an older OVC, pseudo-named Peace aged 16, expressed dismay over unmarried younger female OVC who are beginning to bear their own children, what he called ‘*zvana zvevana*’ or ‘*Children of children*’. He said this practice seems to be bringing in over-population into the CHH that is relying on a very strict and

limited budget. A much younger OVC, pseudo named, Beauty, aged 10, expressed desperation for food was concerned. She replied that ‘*tinoenda kuchikoro tisina zvatadya, mukoma vanozobika manheru vabva kubasa*’ meaning ‘*we go to school on empty stomachs and brother will only cook in the evening after work*’

In addition to the above, another female OVC, Tinah aged 13, remarked saying ‘*zvakaoma veduwe kuve nherera inorarama muhurombo hwakadai*’, meaning ‘*it is tough to be an orphan that survives in such deep poverty*’. Another older adolescent orphan ,Caya ,aged 17 also remarked saying that ‘*pano papurazi vanotipa mabasa akaomesesa sekutema para nekuti atisisina vabereki vanotimirira*’, meaning ‘*they give us heavy work such as pruning tea plants because we no longer have parents here to stand in for us*’.

However, on a more positive note, the orphans concurred that some efforts are made to give medical help as long as the farm clinic has the rightful supplies of medicine for the specific illness and that at least one of the older OVC residing in the CHH is still working for the company.

## **FINDINGS FROM THE OBSERVATION GUIDE**

The following qualitative details present some common psychological disorders observed amongst selected OVC in CHH of Chipinge District farm compound communities. These were noted by teachers, caregivers and researchers during the interactions with the OVC.

### **Determination of poverty levels of the 20 OVC and resultant psychological disorders**

To answer the research question on whether poor OVC in CHH show signs and symptoms of psychological disorders, all care givers and teachers concurred on high poverty levels in CHH. The following were noted as some of the characteristics of the OVC in CHH that confirmed that the orphans were poor, vulnerable and in dire need of aid. The children lived in shanty type of shelter, had no significant source of income, fed on a maximum of two meals per day (sometimes unbalanced), kept no livestock, had inadequate clothing, poor sanitation and generally lived under low SES circumstances. The following table introduces the four major groups of psychological disorders that were evident during interactions with the OVC.

**Table 2: List of Psychological Disorders showing Symptoms and Signs in OVC**

<b>Groups of Psychological Disorders</b>
<ul style="list-style-type: none"> <li>• Anxiety</li> <li>• Somatoform</li> <li>• Dissociative</li> <li>• Affective</li> </ul>

The above table displays classified groups of psychological disorders noted among OVC residing in CHH within farm compounds in Chipinge District. What follows is a further elaboration of on each group showing types, prevalence,

symptoms and signs. Note in each case, an OVC can manifest more than just one of the given signs and symptoms. Hence frequencies and percentages in each table should be read separately.

**Table 3: Anxiety Disorder Symptoms and Signs noted. (n=20)**

Type of Disorder	(f)	%	Signs & Symptoms
General Anxiety	18	90	-feelings of vulnerability, poor appetite, fatigue, apprehension, Troubled, irritability
Panic Disorder	16	80	-overwhelming tension, death phobia, chest pains, hot and cold flashes, exhaustion.
Phobias	16	80	-severe anxiety, avoidance behaviors

In each case it seems, more than 75% of the 20 OVC reflected signs and symptoms of Anxiety disorders with a greater frequency falling within the general anxiety group at 90%.

**Table 4: Somatoform disorder symptoms and signs noted; (n = 20)**

Type of Disorder	(f)	%	Signs & Symptoms
Hypochondriasis	8	40	-persistent fear of the contraction of disease e.g. HIV and AIDS from the infected sick siblings, irrational fears.
Conversion disorders	1	5	-sudden but temporary loss of sensation as in partial blindness , partial deafness, or partial paralysis due to anxiety.

Manifestations of the disorder were noted in the form of hypochondriasis disorder symptoms at 40% and conversion disorder at just 5% of the 20 OVC observed and interacted with.

**Table 5: Dissociative Disorders symptoms and signs noted. (n=20)**

Type of Disorder	(f)	%	Signs & Symptoms
Minor or Partial Amnesia	12	60	-forgetfulness that affects learning and grasping of concepts especially in younger double orphans
Multiple Personality	10	50	-extremes on the good and bad ends of the personality continuum on the same OVC

About half (50%) of the 20 OVC observed reflected multiple personalities whilst 60% of the same OVC indicated signs of forgetfulness.



**Table 6: Affective disorders signs and symptoms noted. (n =20)**

Type of Disorder	(f)	%	Signs & Symptoms
Depression	17	85	Discouraged, down, hopelessness, loss of worthiness, low self esteem, exhaustion for prolonged periods.
Manic- Depressive Bi-polar disorder	5	25	Uncontrollable weeping and suicidal threats interjected with hyperactivity

A greater number (85%) of the OVC showed signs of depression whilst a few (25%) of the same group manifested signs of Manic Depressive – Bipolar disorder.

### **DISCUSSION AND CONCLUSIONS**

The study managed to identify so far, about four types of psychological disorders that are manifested amongst orphans residing in poverty – stricken CHH located in farming compounds, in Chipinge. It has been noted that many of the developmental experiences that OVC are facing are in line with many other research findings that seem to confirm that there exists a strong positive correlation between extreme poverty and the mushrooming of psychological disorders.

The four sets of psychological disorders presented in Table 2 were noted among OVC whose age ranges and gender were presented in Table1. Orphans as young as 8 years were found residing in CHH. This is a confirmation of Chirwa`s (2002) contention that many of our orphaned and vulnerable children have resorted to residing out of their extended families due to negative forms of treatment that they encountered with the relatives of their late parents. Perhaps it is this move, caused by ill treatment that then exposes the OVC to risks of extreme poverty especially if they were born in poverty. This study was conducted amongst OVC residing in poverty – stricken CHH . It is within these CHH that the OVC get so much stressed that we begin to observe manifestation of signs and symptoms of psychological disorders. Authorities studying poverty and stress have since noted that the lives of the poor are more stressful than those of a higher socio –economic status. It becomes even worse when the poverty penetrates into the lives of OVC already residing in CHH where there is inadequate food, indecent clothing, overworking, stigmatization among other stressful challenges. Constant worry over sheer survival are enough to induce psychological disturbances in anyone, especially children.

Being poor children, faced with so many psychological challenges, OVC remain ill – prepared to cope with the stresses they face. They then become more inclined to use ineffective coping mechanisms and are apt to lack the support and encouragement from members of their extended families for they may be regarded as family misfits because they decided to reside on their own as children. Most African families believe that children, alone, cannot cope and so most caregivers would prefer situations where they find these children failing to cope in CHH so that they lure them back into abusive situations within the extended families. Fear of abusive life situations can lead OVC to destitution, thus confirming Abebe`s (2009) idea that endemic poverty leads to destitution.

It is rather unfortunate that most poor people, even the OVC, tend to resist early treatment of noted psychological disorders due to fear of stigmatization. This can go on until the signs and symptoms become acute that many people begin to notice. Perhaps the idea of resisting treatment could be due to financial deprivation and attitudes perpetuated by societal stigmatization and labeling.

From the Children's' voices, we encountered confirmations of our observation of psychological challenges as the OVC narrated their ordeal in the manner of which they are struggling to survive in their poverty stricken homes. It is unfortunate that some of the younger children, as was expressed by Peace, aged 16 years, are beginning to find solace in sexual activities, situations that are bringing in even more OVC into CHH of other under-age OVC. It becomes even worse when these early sex-players indulge in sexual activities with people who are already infected by HIV and AIDS. This observation is in line with Nyamukapa and Gregson (2005) contention that our OVC face a high risk of contracting HIV and AIDS, which can easily perpetuate poor lifestyles in already poor CHHs. Presently, AIDS remains with no cure. Such stressful events can easily lead to psychological disorders.

Beauty, aged 10, also confirmed our observations on psychological disorders that are triggered by hunger for OVC in school. Some OVC from CHH go to school without having had breakfast up to supper time when the head of the CHH (another child) comes home from farm work to fend for resources and eventually prepares supper. What really takes place during the day leaves a lot to be desired. The resultant poverty and malnutrition are risky factors. Of course some care – organizations sometimes send food handouts to schools, but due to reasons beyond their control, the food handouts are not always available hence the vulnerable child continues to suffer.

Caya, aged 17, an older adolescent left school to continue his late parent's labor activities at the farm. He complained of hard work and overworking. Many such OVC working on the farms confirmed that they had deserted school in order to fend for basics for themselves and their siblings. This finding is in concurrence with UN (2002) finding that 40% of the child population in Zimbabwe is not in school. The finding also confirms Nyamukapa and Gregson (2005) finding that most OVC fail to complete school due to family responsibilities that force them to seek employment too soon. As such, children observe others going to school whilst they go to work, memories of school years and the promise of education and hope for the future, keep lingering in their minds. This brings in psychological stress that may eventually give birth to some psychological disorders.

Between 80 – 90% of the poor OVC from CHH presented characteristics of anxiety disorders such as general anxiety, panic attacks and phobias. Of course many try to cope through the use of denial as a defense mechanism; others try to escape by avoiding situations that trigger anxiety. The OVC find it difficult to escape for, sometimes, there is no shoulder to lean on and so the OVC remains inevitably troubled and ill at ease. Onlookers then begin to view the OVC as neurotics, but symptoms of anxiety disorders are upsetting to the sufferers. Hence there is need for intervention by all, so as to liberate the poor and affected children.

Mild cases of somatoform disorders were also noted amongst the poor OVC in the forms of hypochondriasis characteristics at 40% and one (5%) of the 20 participants indicated signs and symptoms of a conversion disorder. Somatoform disorders affect the mind and in particular hypochondriasis is possible in OVC whose parents died of HIV and AIDS. There is a possibility of fear being induced by the fact that HIV and AIDS has no cure yet remaining siblings may be infected by AIDS that caused the death of their parents. As such there is room for stigmatization and labeling on OVC who have been diagnosed of HIV/AIDS. Therefore a possibility for one having a persistent fear for disease is possible. Because somatoform disorders affect the mind, then it is possible to observe more of such psychological disorders if counseling activities are not intensified in farming communities where most OVC find their homes.

Teachers who operated as assistant observers noted signs and symptoms of minor/ partial amnesia at 60% and multiple personality at 50% amongst the school going OVC . In this case the OVC generally showed disturbed memory and problems of identity. With multiple characteristics of poverty and the fact that they are just children, memories and identities can at one time be disoriented. This is in concurrence with some child advocate's remarks that orphan crisis is acute poverty that deprives the child of an immediate caregiver. Most OVC residing in poor CHH within the observed farming communities are living in distress. This necessitates the need for more stakeholder intervention programs for the rather neglected OVC.

Some 85% of the observed children were suffering from affective disorders where our observations noted depression in signs of hopelessness, low self-esteem, discouragement and exhaustion for rather prolonged periods. Some siblings, i.e. 25% of the observed children showed signs of Manic Depressive Bipolar disorders through uncontrolled weeping and some suicidal threats during psychosocial counseling sessions within the farm compounds. All such psychological disorders are perpetuated by acute need deprivation. The situation calls for collaborative efforts by all stakeholder communities to eradicate poverty amongst all children including the parentless children in dire need of aid.

## **RECOMMENDATIONS**

Basing on given findings afore, a number of recommendations are given for stakeholders to try and make orphan hood a less stressful lifeline.

- a) Hunter and Wilson (2000) strategies can be utilized to assist OVC in poverty so as to reduce psychological stresses
  - strengthen support capacity of heads of CHH to protect and care for their siblings
  - mobilize and strengthen community based responses
  - strengthen capacity of children and young people to meet their own needs
  - Ensure that the government, through the Ministry of Health and Child Welfare, protects the most vulnerable children and provide essential services.
- b) Implement possible orphan care approaches namely familial care, community based care, institutionalization and the rights based approach
- c) Self help skills training and parenting skills training for older OVC
- d) Providing an enabling living environment within local farming communities
- e) Stakeholders should find best ways of providing substitutive parenting for affected children

- f) Viable life skills programs should be initiated and implemented in order to capacitate the OVC
- g) Awareness programs to community onlookers on psychological challenges that OVC may face and best assistive devices to use in order to reduce harm
- h) Further research could be carried out in other districts and provinces countrywide in order to establish best ways of assisting OVC in CHH
- i) More effective psychosocial counseling activities should be carried out into communities where OVC are scattered or residing together in CHH
- j) Community based rehabilitation activities should be initiated and implemented by advocacy groups countrywide.
- k) In all our Millennium Goal number 1 efforts to eradicate poverty in Zimbabwe by year 2015, research should continue to help us find best ways of helping every citizen including OVC to escape the bondage of acute poverty .

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