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INTRODUCTION
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Orphan

Recently our society has focussed an increasing concern on child welfare, and with the orphan and destitute children, who has no means and responsible people to look after them. Their living conditions fall from below the accepted standards and there remains a wide gap between them and the rest of the Indian society.

The term ‘orphan’ has both a social and legal meaning rendering it difficult to measure, define and compare data on orphans at different geographical scale. On the one hand it must be understood as a term bounded by legal definitions, and on the other, as a term that describes a host of relationships and social constructs, which vary over space and time. The concept is further complicated by the fact that different organizations have restricted the definition to suit their own objectives as they assisted orphans affected by HIV/AIDS. Traditional (European) understanding of an orphan as “a child, one or both of whose parents have died” (Bideau et al., 2000:316). Children who have lost their mother are referred to as “maternal orphans”; those who have lost their father are “paternal orphans” while those who have lost both parents are classified as “double orphans”. In the global south, these are important distinctions because fathers and mothers provide different types and levels of financial and emotional support. This is particularly relevant in the absence of a welfare state to support single parents.

In 2007, an estimated 145 million children 0 to 17 years old were orphans, having lost one or both parents (UNICFE 2008b). Many million of other children can
be described as vulnerable, due to the effects of illness and poverty. There are many reasons for this situation, including conflict, disease, and accidents. However, in recent times, a new and significant cause of the increased orphan children has been the impact of the HIV pandemic. Worldwide, 15 million children have been orphans due to AIDS, with 11.6 million orphans due to AIDS in sub-Saharan Africa alone (UNICEF 2008b). AIDS is also unique in its impact on double orphans, or children who have lost both parents. If one parent is living with HIV, there is a high likelihood that the other parent is as well and that a child will lose both parents in a short period of time.

Of 153 million children orphaned worldwide, 145 million reside in less wealthy nations where their number has increased dramatically because of HIV/AIDS and other causes. The number of children losing parents to HIV increased from 14.6 million in 2005 to 16.6 million in 2009. While Africa is most often referenced when discussing the orphan burden, Asian countries are caring for 71.5 million orphans. In both Africa and Asia, high mortality among young parents from conditions such as malaria, tuberculosis, HIV/AIDS, pregnancy complications, violence and accidental deaths, and natural disasters are responsible for the large and increasing number of orphans. Tragically, the countries with the highest rates of orphanhood are also among the economically poorest and most under resourced. They are poorly equipped to meet the social, education, nutritional support, psychosocial support, and health care. Global, national and local leaders are struggling to find care solutions for the estimated 143,000,000 children worldwide who have had at least one parent die (hereafter defined as orphans South and east Asia have the largest number of orphans (72,000,000); estimates for Africa indicate that 12% of all children on the continent will be orphaned by 2010.
Children who are orphaned are more likely to suffer from detrimental health and nutritional outcomes; orphaned children are more likely to be stunted compared to non-orphans. Paternal orphans are also more likely to have suffered from recurring sickness in the past month compared to non-orphans. Additionally, caregivers of double and maternal orphans are less likely to report that the child has been sick in the 12 months although maternal orphans are more than twice as likely to report being treated worse than other members of the household, compared to non-orphans (UNICEF 2006). Orphans tend to be defined as children aged under 18 who have lost their mother, father or both parents (UNAIDS et al. 2004). In Asia, the percentage of children who are orphans is smaller, but the absolute numbers total more than that of sub-Saharan Africa. An estimated 37.4 million children are orphaned in South Asia, another 30.1 million are orphaned in East Asia and the Pacific, and 5.9 million children are orphans in the Middle East and North Africa. An estimated 9.4 million children are orphaned in Latin America and the Caribbean (UNICEF 2008a).

Orphans are further categorized by age. The age at which a person is no longer considered a child or orphan varies over time and space. For example, the 1991 Ugandan census considered all those under 18 to be “children” and of these, those who had lost one or both parents to be “orphans”. However, in the 2002 Zimbabwean Population census used 15 years as the cut off point for child/orphanhood (CSO, 2002). Meanwhile in academic studies 15 years has also often been used as the upper limit of childhood and the loss of at least one parent as the definition of orphanhood (e.g. Ghosh and Kalipeni, 2004; Preble, 1990; Foster et al., 1995).

Until 2003, the UNAIDS/UNICEF/UNAID’s children on the Brink report (2000, 2002) also used 15 years as the age limit, but only for maternal and double orphans. In contrast the latest (2004) Children on the Brink report pushes the
The situation of orphaned children is a cause of concern for several reasons: they may have been dispossessed of property by greedy and desperate relatives (Webb 1995; Bedri et al., 1995); they can suffer stigmatization and discrimination associated with the illness and subsequent death of their parents from AIDS (Wright, 2000; Stein 1997; Ntozi and Mukiza- Gapere, 1995; Seeley et al., 1993); many are forced to migrate to extended family (Young and Ansell 2003a b; Ansell and van Blerk, 2004); and an increasing number have left families and are living on the streets (Bourdillon, 1994; Dube, 1999; UNICEF, 2001; KALIYATI et al., 2002; Young and Barrett, 2001 ab).

These children will suffer long before they lose their parents. They may miss out on their education as they may be taken out of school to care for their sick parents. This is especially a problem for girls as they are often the first ones to be given the responsibility of caring for the sick. Studies show that in addition to being deprived of their education, these children often live in households with less food security and have a higher risk of suffering from anxiety and depression.

Orphans lives are depicted as childhood in crisis (Ntozi, 1997). Similarly, Barnett and Whiteside (2002) see orphans as children whose dreams and hopes are shattered by the loss of their parents: “These lives [orphans] are hardly a preparation for the future as a member of a household or a community, least of all as a citizen” (Barnett and Whiteside, 2002:211). While the orphans’ lives are a struggle and hardly ‘prepare’ them for life and adulthood in different ways, Barnett and Whiteside (2002) are in danger of assuming that orphaned children are not survivors. If we recognize children’s agency, then we need to ask how the orphans especially CHHs are
preparing themselves to adulthood with limited parental guidance, their level of competency and resilience (Kesby, Gwanzura-Ottemoller and Chizororo, 2006). As they struggle to support all children, they tend to disadvantage fostered children and to give better treatment to their biological offspring. In fact, many reports state that orphans are likely to be more exposed to poverty, exploitation, abuse, malnutrition and that they have poorer access to health care and schooling than non-orphans (World Bank 2002; FHI 2003; Tadra 2004; UNICEF 2004; UNAIDS 2006; Ueyama 2007). In 2003, UNICEF reported that orphans are generally poorer and less healthy than non-orphaned children (UNICEF 2003). A study from South Africa, for instance, showed negative relationships between orphanhood and school enrollment and orphanhood and health status (Case and Ardington 2006). Studies from other countries, on the contrary, such as Kenya (health) and Rwanda (school enrollment) could not confirm these findings (Lindblade, Odhiambo et al. 2003; Chatterji, Dougherty et al. 2005). The comparison of orphans and non-orphans by using data from the Demographic and Health Surveys from Sub-Saharan countries could also not reveal significant differences between orphans and non-orphans (Ainsworth and Filmer 2006). Ueyama highlights that longitudinal studies are more likely to detect negative correlations between orphan-status and schooling outcomes than cross section studies. It was also observed that maternal death has a more negative impact than paternal death on school enrolment and health (Ueyama 2007).

Orphaned children may also be forced to relocate and in this process lose their social networks and the community they are familiar with (UNICEF, 2008). Residential child care facilities can have serious damaging effects on children’s development and on children’s rights and there is little or no empirical evidence to contradict these findings. In the worst cases children’s rights are being violated by
systematic sexual abuse, exploitation, lack of proper nutrition and health care that severely damages the children’s health, educational deprivation and strict, regimented discipline. Even where the physical conditions are good their will most certainly exist problems associated with any form of residential care. Damaging effects residential child care can have on children include segregation, discrimination and isolation, risk of institutional abuse, lack of personal care, stimulation and attention to specific psychological need and lack of opportunities to learn about adult roles. In addition, admission is often not based on the child’s best interest, but on the needs of the parents or extended family.

Children living in residential child care facilities often have trouble adjusting to adult life when they move out (Foster, 2005; Tolfree, 1995 and 2003). Poverty is also a major reason why orphans are rejected by their extended families. The share number of orphans are becoming too much to handle for poor households. They simply do not have the resources to care for them. The children that have been taken in by their extended families sometimes risk abuse and neglect, but as a result of poverty they also risk being sent out to steal or practice prostitution. The latter is especially a problem for girls. Some children are also denied access to basic education, proper healthcare and nutrition (Ahiadeke, 2003).

According to Maslow (1962), “Human needs range from the basic biological needs to highly complex personal fulfillment and self actualization”. The hierarchy of need is as follows: Physiological need, safety needs, love needs, esteem needs and self actualization need. In addition to aggressive behaviour, Berman also found cases of neurosis, psychosomatic symptoms and other character disorders. The psychological problems commonly observed among these children are neurosis, nightmare, inability to adjust in school, deceit, stealing and aggressive behaviour.
The very basic needs for survival, such as food, shelter, clothing and so on, can not be taken for granted. Their backgrounds are diverse and range from being previous street children to orphaned, some are from families that are unable or unwilling to care for them for various reasons (poverty, broken families, illnesses with parents, imprisonment). Some children have also willing left their families because of abuse and/or neglect.

Orphan may lose access to school because of household poverty, increased household needs for income generation or domestic labor, intra-household stigmatization, and other reasons related to the parental sickness or loss. Ample evidence of orphan enrolment disparities has emerged in many nations, although the size and determinants of inequalities appear to be country-specific. Enrolment inequalities among maternal, paternal, double or all types of orphans have been documented in South Africa (Case & Ardington, 2005), Ghana, Kenya, Madagascar, Malawi, Mozambique, Niger, Tanzania, Zimbabwe, Botswana and Uganda (Case et al., 2004; Miller, 2005; Nyamukapa & Gregson, 2005). One estimate suggests that throughout SSA, orphans are 13% less likely to attend school than non-orphans (Monasch & Boerma, 2004). However, findings are based on an orphan-to-non-orphan attendance ratio that does not account for age, even though age is correlated with orphan status and schooling (Case and Paxson, 2004). Since orphans are more likely to be older and older youth are more likely to be in school, results underestimate the negative effects of orphanhood. Disparities in grade progression were found in each nation where this indicator was examined, including Botswana (Miller, 2005), Niger, Ghana, Kenya, Tanzania, and Zimbabwe (Bicego et al., 2003). Appropriate grade progression is critical because losing ground in the educational system places youth at higher risk for failure and dropping out and low achievement.
may influence decisions about educational investments. In Botswana, maternal and
double orphans were most disadvantaged in grade progression (Miller, 2005). The
household factors that negatively effect orphan schooling include poverty, low
education among household-heads, male household-heads, and high-dependency
ratios (Miller, 2006). In some countries, orphan-based disparities were small
compared to differences due to household poverty. In this case, the negative effects of
orphanhood are exacerbated by poverty because orphans are more likely to live in
poorer households (Sengendo, 1997). However, the primary study that generates this
conclusion (Ainsworth & Filmer, 2002) is based on an orphan-to-non-orphan
attendance ratio.

Child-level factors negatively impacting schooling include weak family ties
with caregivers and orphan type. Although paternal orphans experience inequalities,
double and maternal orphans seem to be at the greatest disadvantage. Age may take a
U-shaped curve whereby young and older orphans (5-8 and 15-17 year olds) are most
likely to experience inequalities while 10-14 year olds are most likely to be in school.
Evidence of gender disparities among orphans is limited, however many researchers
have not stratified data by gender and existing data sources do not provide insights
into the mechanisms that lead to disparities. One crossnationa comparison of 10,
mostly east African nations, controlled for the child’s age and gender, and household
resources (Case et al., 2004). In every country, maternal, paternal and double orphans
were less likely to be enrolled than non-orphans, even compared to children in the
same household. Boys and girls were equally disadvantaged. Differences in enrolment
may be attributed to orphan-specific issues, such as discrimination, emotional trauma,
and the weak relationship between orphans and unrelated caregivers, who make lower
investments in the orphaned child’s education, although the relative contribution of various mechanisms causing to disparities remain unclear (Case et al., 2004).

Indian orphan children under 0-14 year age in Indian is approx 34,01,19,00. Out of that approx 2,32,46,000 are orphan children which is approx 6.8% of total children. With that, approx 8,3,64,000 many children are maternal orphan and 1,57,97,000 are paternal orphan whereas according to the report approx 9,15,000 are double orphan, which means those children has no parents.

**Definition**

An orphan is defined as a child under the age of 18 years whose mother, father, or both biological parents have died (including those whose living status is reported as unknown, but excluding those whose living status is unspecified (Helen Meintjes & Katharine Hall, 2012).

A maternal orphan is a child whose mother has died but whose father is alive;

A paternal orphan is a child whose father has died but whose mother is alive;

A double orphan is a child whose mother and father have both died.

A single orphan is therefore a maternal orphan or a paternal orphan.

**The personality characteristics of orphans**

- The personality make up the orphans as a group is different from that of the non-orphans. The orphans show psycho-neurotic trends in the form of exhibition of more negative emotions, feelings of anxiety, inferiority, dejection, helplessness, insecurity, shyness, reserve, passivity, anxiety and emotional instability.

- Orphans seem to acquire a feeling of hostility towards authority and society.

- Orphans have a less positive attitude towards their elders and more negative attitude towards society than non-orphans.
• Home, social adjustment and health adjustment are unsatisfactory among orphans.

• Orphans’ personality is dominated by negative emotions.

• Orphans boys as well as girls have a less positive attitude towards life, humanity and religion than non-orphans.

• Orphans are observed to be less positive attitude towards religion, less cheerful, less co-operative and less social in comparison with non-orphans.

The effects of being an orphan

Aside from the devastating emotional impact of losing their parents, orphans are susceptible their entire lives. Inhibited social, cognitive, psychological and physical development are all common long-term effect of orphanhood. Typically, the younger the age of a child when orphaned and the longer he remain without a home, the more drastic the impact that his experiences as an orphans will have on his development.

Inhibited Physical Development

While affectionate touch is associated with decreased stress levels, touch deprivation and the resulting stress increases are association with weakened immune systems, decreased physical recovery speeds, abnormal growth, and poor overall health even when all other basic needs are fulfilled. A study by researchers at the University of Minnesota found that the natural growth hormone levels of children living in orphanages tended to be lower than normal and that puberty was typically delayed by a year and a half to two years. Another study conducted by researchers at the University of Oxford concluded that the heights of children who lost their parents before age 15 average a final height approximately 2 centimeters shorter than un orphaned individuals. In a 2003 study, a group of Korean infants living in the
orphanage received 15 minutes more exposure to a female voice, affectionate touch and eye contact twice a day for 4 weeks. Compared with other infants living in the orphanage, they experienced fewer illness and significant increases in weight, body length and head circumference by six month of age.

**Increased susceptibility to psychological risk emotional problem**

Increased susceptibility to depression and anxiety is another result of the heightened stress level associated with being an orphan. A 1997 study by Makerere University found that psychiatric disorder were 3.5 time more likely among children in orphanages, compared with children living their families. Because young children may not yet understand the finality of death, they are unable to fully experience the mourning process which help adults to cope and as a result may grow up with unresolved anger, depression and anxiety.

**Inhibited cognition and mental development**

Cortisol is one stress hormone whose levels increase due to touch deprivation. At consistently high levels, it inhibits normal brain tissue development and damages existing brain tissue. since one of the most impacted regions is the hippocampus, responsible for leaning and memory, affection –deprived orphans tend to experience leaning difficulties. A study comparing intelligence quotients of Romanian orphans in foster care with those of children in orphanages suggests that caring family environments can counter at least some of these effects in females. Girls in foster care averaged IQ scores of 82, compared with the general population’s average IQ of 100, while those in orphanages averaged IQs of 70. On the other hand, boys in either scenario averaged IQ scores of 60.

**Inhibited social development and connectivity**
Unhealthy social development is another long term effect. Orphans are typically deprived of consistent and genuine exposure to the love, affection, warmth and care that contributes, trust in others, and a sense of self-worth. Touch-deprived children are more susceptible to paranoia, insecurity and distrustfulness.

**Orphan fact**

Orphans are children who have lost both of their parents due to death or the termination of legal parental rights. A family member or guardian is unavailable to care for the orphan; many times the orphan's needs are not met due to lack of funding and sub-standard conditions.

**Physical**

According to The Effects of Early Social-Emotional and Relationship Experience on the Development of Young Orphanage Children, orphans raised in globally deficient orphanages weigh less, have less girth and are shorter than children who are not raised in orphanages. This is due in part to many aspects of their early environment, such as poor nutrition, lack of sufficient physical exercise, and shoddy medical care. Another possible cause is psychosocial dwarfism, a condition that children who are exposed to severe social and emotional neglect become susceptible to when growing up in orphanages.

**Behavioral**

Orphans living in global deficient orphanages display a delay in behavioral development. Acting out emerges in adolescent orphans whose parents have died from AIDS. Orphans tend to engage in atypical behavior that begins as overly passive and grows to aggressiveness in the teen years. Being easily distracted and overreacting are other behavioral characterizations of orphans living in substandard orphanages. Depression, withdrawal from social activities, moodiness, loss or
increased appetite, and sleep problems are common reactions in adolescent orphans who have lost parents to AIDS. Sometimes, alcohol and drug use can be a manifestation of extreme depression in these adolescent orphans.

**Relationships**

A child's relationship with his parents is a large part of how he defines himself, and when his parents die, the evolution of his identification of self is halted. The lack of a mother-child relationship impedes an orphan's ability to form genuine attachments. Orphans tend to have trouble developing proper relationships with peers and yet display indiscriminate friendliness in an effort to reach out to others. Of those adolescent orphans who are able to be raised by another family member or members, some assume a "superchild" type of role by taking over some parental responsibilities like adult decision making and household chores. Seeking approval, they can even provide emotional support to their guardian, much like a co-parent.

**Mental performance**

Orphans tend to display rigidity in thinking and have poor logical reasoning skills in comparison to children raised by parents. They have difficulty creating solutions to specific problems and tend to have overly concrete thought processes.

**Understanding**

Orphans younger than three or four tend to cling to magical thinking; having not grasped the full meaning of death yet, some believe that wishing their parents alive again is enough to bring them back. Some children who were orphaned around age ten or eleven understand the finality of death; those orphans who have lost one or both of their parents to AIDS may believe that death itself is contagious.
Health

Health is the level of functional or metabolic efficiency of a living being. In humans, it is the general condition of a person’s mind, body and spirit, usually meaning to be free from illness, injury or pain (as in “good health” or “healthy”). The World Health Organization (WHO) defined health in its broader sense in 1946 as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." The WHO’s 1986 Ottawa Charter for Health promotion further stated that health is not just a state, but also "a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities."WHO famously defines health as: a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 2001b, p.1). Three ideas central to the improvement of health follow from this definition: mental health is an integral part of health, mental health is more than the absence of mental illness, and mental health is intimately connected with physical health and behaviour. The term "healthy" is also widely used in the context of many types of non-living organizations and their impacts for the benefit of humans, such as in the sense of healthy communities, healthy cities or healthy environments. In addition to health care interventions and a person’s surroundings, a number of other factors are known to influence the health status of individuals, including their background, lifestyle, and economic and social conditions; these are referred to as "determinants of health".

According to the World Health Organization, the main determinants of health include the social and economic environment, the physical environment, and the person's individual characteristics and behaviors. Factors that have been found to influence whether people are healthy or unhealthy include: Income and social status,
Parents are, without doubt, the most important caregivers and attachment figures providing emotional support and consistent nurture. In his works on early child development, Bowlby (1982) stresses the role of the relationship between caregivers, in particular mothers, and their children in shaping subsequent development and personality. Losing a parent during childhood is a traumatic event that shapes child development beyond purely economic consequences. Above all, parental death can have a lasting effect on children’s emotional status which, in turn, can keep them from studying or attending school altogether (Gertler et al., 2004).

Dozier et al. (2008) review, inter alia, evidence on the relation between the loss of an attachment figure and psychological disorders in adulthood and find a strong correlation between depression and anxiety and early maternal loss. Depressive episodes, in turn, can have a profound effect on both educational performance and physical health (Needham, 2009; Katon, 2003). A report from the National Scientific Council on the Developing Child (2010) concludes that early experience of traumatic events which produce lasting fear and anxiety can have lifelong consequences by disrupting the developing architecture of the brain, particularly in areas involved in emotions and learning. In the absence of the buffering protection of adult support, such chronic stress in early childhood may even be toxic to the developing brain. Makame et al. (2002) find that orphans in Tanzania’s capital Dar Es Salaam have more internalizing problems which put their long-term mental health at risk. For the case of Zimbabwe, Nyamukapa et al. (2008) show that orphan hood is associated with
high levels of psychosocial distress. Children who have been orphaned by AIDS are likely to suffer from the direct trauma of parental illness and loss, as well as from stigma and discrimination. Such aggravating effects may result in even worse school performance and attendance/graduation rates (Sharma, 2006).

In South Africa, a study of 30 orphaned and 30 non-orphaned children ages 6-19 living in poor urban areas found that orphans were more likely to have difficulty concentrating, to report somatic systems, and to have constant nightmares. Orphans scored 73% above the cutoff for Post-Traumatic-Stress-Disorder (Cluver and Gardner 2005). There were no differences based on the child's age, gender, or time since parental death, although the sample was small. These are small, qualitative, purposefully sampled studies, yet they illustrate the grave emotional state of some orphaned children. Still, it is unclear if these children are representative of orphans throughout Uganda, Zimbabwe and elsewhere. The literature on the psychosocial situation of OVC still has gaps, including incidence and prevalence rates of depression and other psychological disturbances; and information on the emotional problems associated with critical periods, such as when one or both parents become symptomatic, when parents require intensive care, when a parent dies, during placement in a new care situation or subsequent placements, or after the loss of multiple caregivers. For example, in Uganda, 6-20 year olds reported losing hope and becoming less optimistic about the future or even living a long time when they recognized their parents had AIDS (Sengendo, 1997). And in Tanzania, depressed orphans' had lost parents many years prior to the study, possibly indicating that elevated depression levels were chronic, and related to current circumstances rather than an acute grief reaction to parental death. Of course, acute incidents may trigger depression that deepens when left untreated. Another important research gap are
details on the mediating and moderating factors that compound or act as a buffer against distress, and the range of psychosocial disorders. Finally, emotional trauma is linked with high-risk behavior such as unprotected sex, alcohol and drug use, dropping out of school, and suicide, and yet there is little insight into OVC emotional health and high-risk behaviors.

In the capital cities of Swaziland and Botswana, 39% and 33% of 15-24 year old women, respectively, were HIV positive in 2003 (UNAIDS, 2005). International goals on HIV prevention prioritize improving efforts targeted at 15-24 year olds given that 50% of new infections occur in this age group (UNGASS, 2001). OVC are at a heightened risk for early initiation of sexual activity and contracting HIV for several reasons. The trauma of losing a parent, growing up in a distressed home, or with lower quality care, may lead OVC to engage in sexual activity to fulfill emotional needs. While orphans are more likely to live in poorer homes, low socio-economic status heightens risk of HIV infection through direct and indirect pathways (CDC, 2005). Poverty may directly increase the risk of infection if poor orphans sell sexual favors to earn money, and indirectly increase risk if it diminishes access to healthcare services where condoms are distributed and sexually transmitted infections treated. In addition, while educational attainment is positively correlated with lower risk of HIV transmission, orphans are at higher risk of dropping out of school (Bicego et al. 2003; Case et al., 2004; Monasch & Boerma, 2004). Out-of-school-youth have diminished access to prevention education, are more likely to be sexually active younger (CDC, 2005), and may fail to use HIV protection methods (UNESCO, 2005). In the sole study of sexual behaviors among children affected by AIDS, the HIV prevalence rate in female OVCs aged 15-18 was 3.2% versus 0% among non-OVCs (Gregson et al., 2005). In this study from Manicaland, Zimbabwe, orphans and vulnerable children
were 75% more likely than their counterparts to have STI symptoms. Teenage pregnancy was more prevalent among OVCs than non-OVCs (8.3% versus 1.9%). OVCs were also more likely to have initiated sexual relations and married, but there were no differences in the number of lifetime sexual partners. OVCs were also less likely to be enrolled in secondary school than their counterparts. Finally, among all youth in the study, maternal orphans and girls had the worst reproductive health and access to secondary school. These are critical findings suggesting that OVC status may further fuel the AIDS epidemic. Additional research examining the sexual health of OVC is a vital piece of prevention efforts. Given that OVC may be at greater risk of sexual abuse because they lack parental protection, research investigating sexual or physical abuse based on orphan status also needed. The same mechanisms that increase the likelihood that children affected by AIDS will engage in high-risk sexual activity may also increase the risk that OVCs will engage in other risk-taking behaviors such as substance abuse, which increases the risk of HIV infection.

Orphans are becoming a highly mobile population. Several small qualitative studies have found that orphans migrate more often than non-orphans (Ansell & Young, 2004; Foster, Makufa, Drew, & Kralovec, 1997; Foster & Williamson, 2000; Makame et al., 2002; Masmas et al., 2004; Urassa, 1997). In a mixed-method study in Malawi and Lesotho, children who were sent to live with extended family commonly moved over long distances and between urban and rural areas (Ansell & Young, 2004). Youth were not consulted or informed about these moves and most children found migration traumatic (Makame et al., 2002). While many children faced a range of problems integrating into new families and communities, they usually settled into new environments over time. In Zimbabwe, paternal orphans were 40% and double orphans were 100% more likely than non-orphans to move during a three-year follow-
up. Maternal orphans moved at the same rate as non-orphans. Moves tended to be from towns to rural settings, between households of similar socio-economic status, and occur before parental death.

Liu et al. (2009) who study the impact of parental absence on children’s mental health in Chinese migrant households. They find that children approaching adulthood develop fewer symptoms of anxiety and depression than their younger counterparts. Overall, it is likely that the trauma of parental loss is particularly harmful for children in their early stages of human capital formation.

Physical Health

Physical health is concerned with smooth functioning of various physiological system of the body. A person should be fit to do all his routine work without any difficulty. He must possess normal body weight, good vision, healthy skin, proper dental conditions, good neuro-muscular coordination, etc. Mental health disorders are an enormous social and economic burden to society by themselves, but are also associated with increases in the risk of physical illness (World Health Organization, 2009).

Mental Health

Mental health is concerned with balanced state of mind. A person must be free from stress, tensions, conflicts, confusions, depression, etc. A person must posses problem solving attitude, he should be able to think about right or wrong, etc. “Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community” (World Health Organization, 2001). "Mental health is the foundation for well-being and effective functioning for an individual and community. It is more than the absence of mental illness; it is a
resource vital to individuals, families and societies" (British Columbia, Ministry of Health, 2007).

Social Health

Social is concerned with the adjustment of an individual within the society. A person is considered to be socially healthy if he is able to adjust himself/herself among the people of difficult religion, region, status, etc. If an individual is not socially healthy, he/she may develop inferiority complex among themselves.

Security – Insecurity

The concept security, and insecurity, denotes a belief and a feeling, which are part of human repertoire. A belief is defined as a proposition to which a person attributes at least a minimal degree of confidence (Bar-Tal, 1990; Bern, 1970; Fishbein & Ajzen, 1975; Kruglanski, 1989). A proposition is a statement about an object(s) or relation between objects and/or attributes. A minimal degree of confidence refers to the likelihood of the proposition to be true from the person's perspective. Beliefs may arouse affective reactions in the form of feelings (Arnold, 1960; Fiske, 1981; Leventhal, 1984). 'Security' then is one category of beliefs covering different contents. These beliefs, concerning basic human needs of safety (Maslow, 1970), are accompanied often by feelings of unpleasantness, anger, or frustration in the case of insecurity and feelings of pleasantness, satisfaction, or calmness in the case of security. Specifically, security, or rather insecurity, is defined as an appraisal of a perceived danger in the environment to which a person perceives threat (Jacobson, 1991). In essence, two beliefs constitute the set of beliefs about insecurity. One refers to the appraisal of an event(s), condition(s), or situation(s) as an indicator of threat or danger (primary appraisal) and the other refers to an evaluation of available defenses and the ability to cope with the perceived threat or
danger ('secondary appraisal'). Accordingly, people form beliefs about being secure when they do not perceive threats or dangers, or even when they perceive threats or dangers, which they believe to be able to overcome.

In contrast, people form beliefs about being insecure when they detect dangers or threats and see difficulty in coping with them (Lazarus, 1991; Smith & Lazarus, 1993). In reality, beliefs about security or insecurity are not dichotomous, but vary on the range of which high level of insecurity and high level of security are the extreme poles. The term 'security' according to Webster’s New Twentieth Century Dictionary, is the condition of being firmly fastened or fixed (Webster, 1962, p.1641). An individual feels secure when he meets his condition. Several psychologists have stressed that a sense of security is essential for healthy growth and development. According to them, the mental condition of an infant is directly related to whether or not he is loved and the infant gets his first feelings of security by being handled gently or tenderly. (Lango and Hershey, 1981). There are several forms of security: financial, physical, social, interpersonal, & emotional.

- Financial security means we have enough money income, assets, savings, investments, insurance to prevent most financial troubles in the future.
- Physical security means that our living and working conditions are safe from fire, flood, riot, war, accident, & violence. And health security means that we have good ways of protecting ourselves from disease, injury, & disability.
- We are socially secure when our social standing is assured, when we have the approval and recognition of the people we respect.
- Interpersonal security refers to close personal relationships. We often seek relationship-stability throughout marriage and family. We all appreciate good
personal relationships, but children, especially, need the security and protection of dependable, loving parents.

- Emotional or psychological security means we can depend on ourselves. We are self-confident, internally-strong, & self-reliant.

Insecurity is characterized by the loss of emotional stability or self-condition. Sufferers perceive themselves to be unloved, inadequate or lacking self-worth. Insecurity can lead to psychological problems or over-compensatory behaviour such as bullying or aggression. According to Carroll (1956), emotional security is essential for physical and mental health. Persistent insecurity, according to him, keeps the organisms in a stirred-up state. Eventually, such a disturbed condition may result in both physical and mental disorders.

Insecurity feeling manifests itself in several ways. Chronic anxiety, scrupulosity, excessive timidity, social inadequacy and perfectionistic idealism are all symptoms of the feeling of insecurity. If they become chronic, they may lead to personality disintegration. Any situation in life may develop insecure feeling in some people. Aggressive and hostile behaviours are common when insecure persons try to compensate. They are insensitive and less understanding. Irresponsibility, lack of dutifullness and breaking of relationship is marked in an insecure persons. Fictional illness, compulsive actions, overeating and over drinking etc. can be the fruits of insecurity.

Insecurity affects people in a number of ways either during specific situations or in everyday life. Some people find that in the workplace they feel secure but in social situations they feel uncomfortable. In some cases, insecurity can completely cripple an individual leading to low self-worth. Some insecurity is natural and can act as a warning signal when faced with risky situations. Severe insecurity is often the result
of a traumatic experience, abuse or neglect during childhood. Some people become insecure after a bereavement or loss. Insecurity within a relationship is often caused by a perceived loss of trust in a partner or loved one. The overriding cause of insecurity is typically due to low self-esteem. Strong feelings of fear about every situations and activities can be extremely limiting causing a vicious cycle that is difficult to break.

Insecurity can have a variety of associated symptoms which are usually signs of other conditions such as anxiety. Symptoms can be physical, emotional and psychological and may include: Self-doubt, indecisiveness, obsessing, low self-esteem, fear, jealousy, increased heart rate, dependency, being defensive, materialistic, overtly authoritative, and overtly competitive.

On the basis of people's descriptions, type of insecurity can be broadly linked to the following factors: Survival and livelihoods, Natural disasters, crime and violence, Persecution by police and lack of justice, Civil conflict and war, Macro policy shocks and stresses, Social vulnerability, health, illness and death.

**Self-Expression**

The right to freedom of expression is justified first of all as the right of an individual purely in his capacity as an individual. It derives from the widely accepted premise of Western thought that the proper end of man is the realization of his character and potentialities as a human being (Thomas Emeson, 1963). Self-expression is a notion that is closely associated with positive concepts, such as freedom, creativity, style, courage, self-assurance, and even healing and spirituality. Thus, individuals are urged to express themselves whenever possible, and self-expression is expected to be, by and large, good and beneficial. The freedom to express one's opinion, the freedom of Speech, is one of the legally protected basic
human rights. This social understanding of self-expression and its psychological consequences have been supported by scientific evidence as well. Generally speaking, psychological findings support the idea that self-expression affects people in positive ways (e.g., Freud, 1920/1996; Pennebaker, 1990). Yet many studies in cultural psychology show that the concept of self varies greatly across different cultural contexts, and to the extent that the meaning of the self differs, how people engage in any self-actions, such as self-expression, and their psychological consequences could differ as well. The specific nature of how people express themselves and how different forms of expression affect people seem to vary greatly depending on the assumptions about the self and its relationship in a sociocultural context.

Taylor, Shelley E.; Brown, Jonathon D. (1988) Many prominent theorists have argued that accurate perceptions of the self, the world, and the future are essential for mental health. Yet considerable research evidence suggests that overly positive self-evaluations, exaggerated perceptions of control or mastery, and unrealistic optimism are characteristic of normal human thought. Moreover, these illusions appear to promote other criteria of mental health, including the ability to care about others, the ability to be happy or contented, and the ability to engage in productive and creative work. These strategies may succeed, in large part, because both the social world and cognitive processing mechanisms impose filters on incoming information that distort it in a positive direction; negative information may be isolated and represented in as unthreatening a manner as possible. These positive illusions may be especially useful when an individual receives negative feedback or is otherwise threatened and may be especially adaptive under these circumstances. To define the self expression of one’s own personality, feelings, or ideas, as through speech or art: “Self-expression must pass into communication for its fulfillment” (Pearl S. Buck).
Self-expression—the expression of one’s individuality (usually through creative activities) expression style, style—a way of expressing something (in language or art or music etc.) that is characteristic of a particular person or group of people or period; “all the reporters were expected to adopt the style of the newspaper” Self-expression effect on specific psychological processes, including cognitive functioning, preference, self-esteem, and interpersonal representation of a thought, feeling, or emotion that is an element of a person.

Most psychologists can probably agree on a description of emotion, e.g., what phenomena to include in a discussion of emotion. The enumeration of these parts of emotion are called the “components of emotion” here. These components are distinguished on the basis of physiological or psychological factors and include emotion faces, emotion elicitors, and emotion neural processes. The facial and bodily behaviors called “emotion expressions” are indicators of emotion, as opposed to effecting some action or achieving some goal. These expressions can differentiate one emotion from another.

Happy expressions are universally and easily recognized, and are interpreted as conveying messages related to enjoyment, pleasure, a positive disposition, and friendliness.

Sad expressions are often conceived as opposite to happy ones, but this view is too simple, although the action of the mouth corners is opposite. Sad expressions convey messages related to loss, bereavement, discomfort, pain, helplessness, etc.

Anger expressions are seen increasingly often in modern society, as daily stresses and frustrations underlying anger seem to increase, but the expectation of reprisals decrease with the higher sense of personal security. Anger is a primary concomitant of interpersonal aggression, and its expression conveys messages about