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What Determine the Depression Among Orphan Adolescents? An Empirical Assessment

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ABSTRACT:
Orphan adolescents are a special group of people who are generally deprived and prone to develop psychiatric disorder even if reared in a well-run institution. Depression can negatively influence health and life such as lack of productivity, relationship trouble and Suicide, Alcoholism or Drug Dependency. The focus of this paper is assessing the prevalence of depression and its associated factors among Orphan adolescents in Hawassa city. A cross-sectional design was used and a total of 277 orphans were selected from nine orphanages using proportional random sampling technique to collect the information. The collected data was entered into the EPI-INFO 7.0 software, and exported to SPSS version 20 for statistical analysis. The strength of association between variables was assessed using a crude and adjusted odds ratio by running logistic regression with 95% confidence interval. The results indicate that the overall prevalence of depression among the orphan adolescents was found to be 28.5%; the majority (54.3%) of them were within the age group of 15-19 years and this group diagnosed with chronic physical disease. Poor social support, having a chronic disease, the orphans' age group, and the length of stay in orphanages were the factors associated with depression. The outcome of the depression for the last one year are suicide attempt (3.9%), unsafe sexual practices (15.7%), decreased their school attendance and performance (31.4%), felt failure (24.1%), and 38.2% lost their appetite. About 92.4% of the respondents had no history of substance use within the center, 62.5% did not feel discrimination from their friends and society. However, 54.9% faced physical abuse from their families. Out of sample nine orphan centers under study, only two of them had a psychiatric clinic and a depression prevention activity practice. It needs integrated work to solve the problem, the orphanages must collaborate with other organizations to provide proper psychiatric services to diagnose and treat depressed orphans.

Key Words: Orphan Adolescents, Depression, Orphan Centers and Social Support

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1. Background of the study

Depression is a disorder that is defined by certain emotional, behavioural, and thought patterns. Adolescent depression is levelled as depressed mood, depressive syndrome, and clinical depression. Depressed mood is sadness at various times in response to an unhappy situation. Depressive syndrome is experiencing anxiety with other symptoms such as feeling sad, lonely, unloved, and worthless. Clinical depression is the manifestation of five or more depressive symptoms lasting continuously for two weeks and impairing current functioning. Depression is under-recognized among adolescents because depressive symptoms are considered a familiar part of adolescents' experience (Petersen et al., 2019).

The World Health Organization (WHO) defines as cited by Ijaz S, (2020). depression as a common mental disorder in which symptoms include depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration. Depression is a deep sadness with long-term, harmful effects on the health and development of the individual (Mental Health, 2018). The prevalence of depression is reportedly high among people living in low and middle-income countries. Moreover, depressed people are twice as likely to commit suicide and to die prematurely compared to those who do not have depression (Lim et al., 2020).

Orphan adolescents are a special group of people who are generally deprived and prone to develop psychiatric disorder and, children adolescent orphaned by Acquired Immune Deficiency Syndrome (AIDS) were more likely to report symptoms of depression, peer relationship problems, and posttraumatic stress than non-orphaned children (FHAPCO, 2019). Orphan-hood is a period that involves many psychological and emotional problems (Ijaz S, 2020). It is considered stressful and a risk factor for the poor mental health of adolescents. Orphan adolescents are a special group who are generally deprived and prone to develop psychiatric disorders even those reared in well run-institutions (Demoze et al., 2018).

Different works of literature found that orphans with low social support, age group of orphans, chronic physical disease, presence of visitors, counseling service, facing discrimination from their friends and community, duration of stay in orphan centers and having no biological relatives were the factors responsible for the depressive disorder. Therefore, Orphan Adolescents are highly in need of effective

counselling to cope up with their problems (Mutiso and Mutie, 2019).

Different studies in different countries revealed that the range of 2.6% to 19.4% of orphan adolescents had depressive symptoms (Jane et al., 2016). In Sub-Saharan Africa depression in childhood and adolescent ranges between 7.6% and 34.7%. For example, depression in Uganda was 7.6 %, in Egypt it was 20%, and in Ethiopia it was 25.3- 34.7% (Ibrahim et al., 2017).

Depression can negatively influence health and life such as lack of productivity, relationship trouble and suicide, alcoholism or drug dependency. Depression can raise risk for chronic diseases such as cardiovascular disease, diabetes, alzheimer's, stroke, and more, trouble on relationships leading to loss of friendships, severed connections, and break ups or divorces. Suicide tragically in Ethiopia, the prevalence of suicidal behaviors ranged from 0.9 to 60% for suicidal ideation, 3.8 to 27% for suicidal attempt, and 13.96% per 100,000 for completed suicide (Fekadu et.al., 2018).

Prevention strategies for depression include effective community approaches to school-based programs to enhance a pattern of positive coping in children and adolescents. There are effective psychological treatments depending on the severity and pattern of depressive episodes over time, Health-care providers may offer psychological treatments such as behavioral activation, counseling, cognitive behavioral therapy, interpersonal psychotherapy, and/or antidepressant medication (WHO, 2020).

2. Statement of the problem

Orphan-hood is a growing worldwide phenomenon and there are an estimated 153 million orphans globally (Babedi and Pillay, 2019). Half of the orphans worldwide are adolescents and approximately 42.5 million orphans in Africa (UNIADS, 2020). Sub-Saharan Africa has approximately 19.2 million orphans. South Africa is reported to have 3.7 million orphans, which constitutes 17% of all orphans globally (UNICEF, 2020).

In Ethiopia, 14% of children are living with their mothers but not with their fathers whereas only 3% live with their fathers. This clearly indicates that in case of divorce or separation, carrying for children is mainly the responsibility of women. Also 11% of children are living outside of the family setting with neither of their biological parents. Some of these children are orphan who have lost their parents due to death (Ethiopian Demographic Health Survey, 2016).

Globally, one in every five children and adolescents suffers from a mental 2 disorder, and two out of five who require mental health services do not receive them (WHO, 2021). Major depression in adolescents impairs their performance at school or work and hinders interactions with their friends and family (Mutiso and Mutie, 2019). It affects their physical and social life and impinges on their human rights, economic, educational, productive, cultural, and reproductive rights, and has a notable negative impact on the quality of life, especially in adolescents aged 10–19 years (Abhishek et al., 2017). Research found that orphans to be more depressed, more anxious, less optimistic about the future, and more likely to express anger feelings and have more disruptive behaviors compared to non-orphans (Lassi et al., 2018).

The findings of different studies indicated that orphan children are highly vulnerable to different psychological disorders such as post-traumatic stress disorder (PTSD), depression, anxiety disorder, and low self-esteem. Therefore, orphan children are highly in need of effective counseling to cope with their problems (UNICEF, 2019). In a comparative study between adolescents living in an orphanage in the community and orphanage center it was reported that participants living in the orphanage center had significantly higher anxiety, depression, negative self-concept, hostility, and have low self-esteem (Gupta and Vishwavidyalaya, 2020).

Yet there has been little research done on this area and makes it difficult to find baseline data on how to evaluate and improve psychological support programs especially in Hawassa and this study was conducted to assess the magnitude of depression, to identify the factors associated with it and to indicate main intervention areas to make recommendations for the program planners and policymakers to review and change or strengthen existing care and support programs for children in the orphanages in the region and in the country as well.

3. Specific Objectives

i. To assess the prevalence of depression among orphaned adolescents in Hawassa city.
ii. To identify the factors associated with depression among orphaned adolescents
iii. To assess the outcome of depression disorder among orphaned adolescents
iv. To understand adolescents' depression prevention and treatment practices in the selected orphan centers.

4. Methodology Adopted

The study employed an institutional-based cross-sectional survey design and a mixed research approach. Both primary and secondary information were used to addressed the objectives. In order to select sample orphanages and sample adolescents, a multi-stage sampling procedure was applied. In the first stage, nine orphan centers were purposefully selected because there are only nine orphan centers which are working with adolescents age between 10–19 in Hawassa City, and 423 are found in these centers (Hawassa city Health Bureau, 2022). The sample size of 252 was calculated using population proportion formula with 95% confidence level. Also 10% non-response rate of 25 included, thus total sample size was 277. This sample size was allocated proportionally to the total number of orphans in the sample orphanages. Finally, respondents were identified randomly. Semi-

structured interview schedule was used for data collection.

The collected data was checked for completeness, consistency and entered into EPI-INFO (version 7.0) and exported to SPSS (version 25) for analysis. Frequencies, percentages, mean cross-tabulation, and odds ratio were used for analysis of data. The data was checked for normality and outliers. Bivariate and multivariable logistic regression analyses were carried out to identify the independent predictors on depression. All variables with a p-value less than 0.25 were entered into a multivariable logistic regression.

Model Specification

Logistic regression is a statistical technique used in researches for analyzing the relationship of dependent variable no one or more independent variables. The dependent variable is depression among the orphan adolescents and the independent variables are socio demographic factors (age, sex, education, and income), social support (social support from the family and friends), behavioral factors (substance use and alcoholism); and co-morbid disease (past mental illness, having mental illness, and chronic illness) and potential interactions (duration of stay in the center, getting counseling services within the center, and discrimination).

According to Nadler and Wedderburn, (1972) model of logistic regression,

$$\text{Log odds of outcome} = \beta_0 + \beta_1 x_1 + \beta_2 x_2 + \ldots + \beta_k x_k$$

The transformation of the probability, or risk, π of the outcome into the log odds is known as the logit function.

$$\text{logit}(\pi) = \log\left(\frac{\pi}{1-\pi}\right)$$

At the end, the exponential funtion of the regression coefficient (β) will be used as an OR.

5. Conceptual Framework

This conceptual framework of depression among orphan adolescents was developed through a review of various literatures and presented in figure 1.

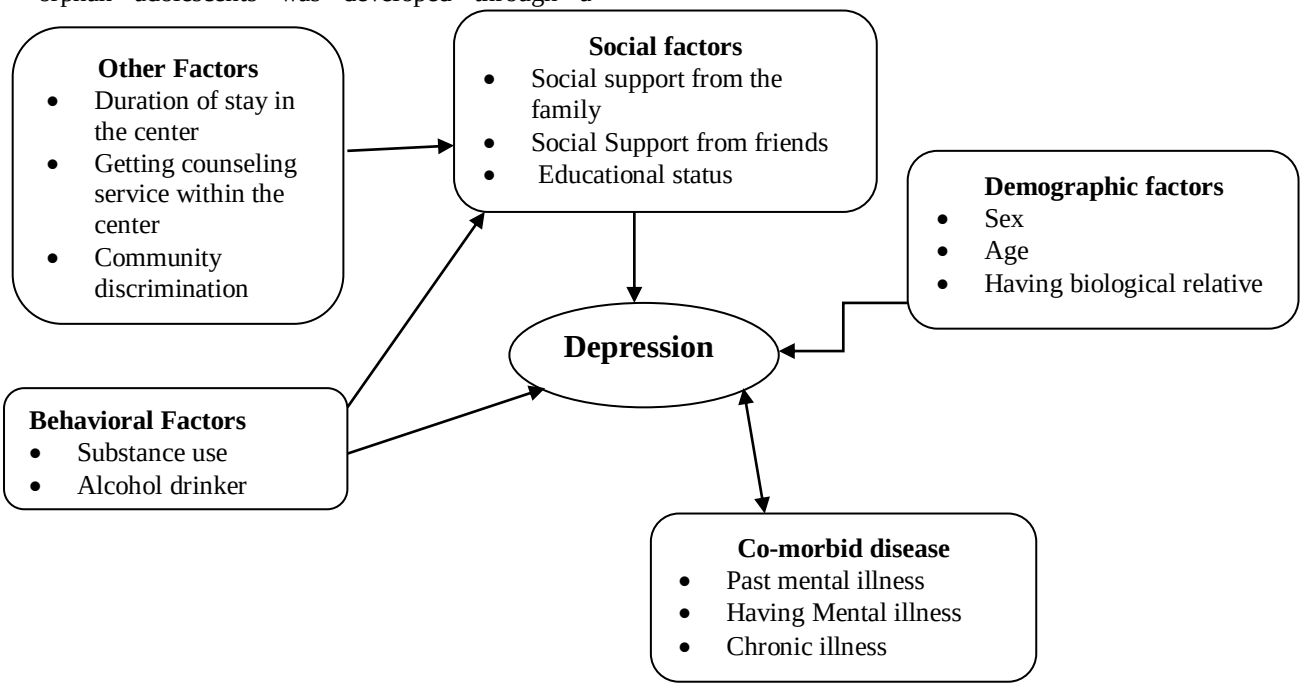

Figure 1: Conceptual Frame Work

Source: Developed by the Authors

6. Results and Discussion

6.1: Socio-demographic Characteristics of the Respondents

Distribution of Respondents by Sex: It is primarily associated with physical and physiological features, including chromosomes, gene expression, hormone levels and functions, and reproductive and sexual anatomy. Assessing respondents' sex gives a clear image of which sex group is more affected by depressive disorders. Out of 277 respondents, majority (61%) is female and 39% male. This implies that in the sample orphan centers, females are dominant and shows female respondents are more vulnerable after losing their parents. Yesharege (2019) believes that because of different

socioeconomic reasons, females get more chances to enter orphanages.

Distribution of Respondents by their Religious: Religion refers to a set of beliefs about the existence, nature, and purpose of the universe, usually involving the worship of one or more deities. Religion also involves ethical and moral guidelines for living and assessing the same gives a clear picture of the depression's effects. Religiosity mitigates symptoms of depression, possibly by providing a social support system and a stable community of likeminded individuals to serve as a coping mechanism, and by providing positive outlooks on stressful situations (Miler et al., 2019). Majority (40.1%) of respondents are Protestant, followed by Orthodox (30.7%), Muslim (9.4%), Catholic (13.7%), and others (6.1%). The protestant faith has the most adherents in comparison to other religions, according to the Ethiopian Central Statistics 2020 report for the Sidama region; this is also true for orphans who live in orphanages as shown in Figure 2.

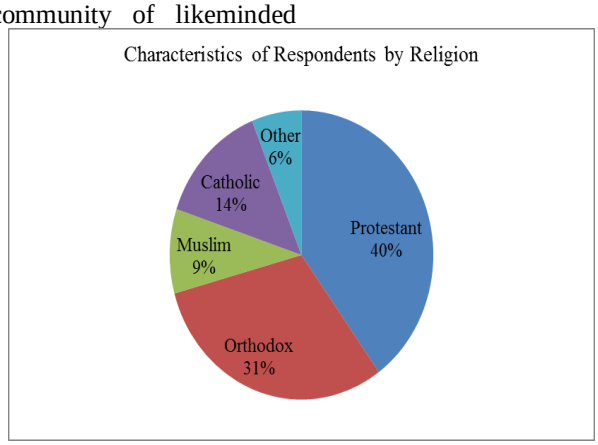

Figure 2: Distribution of Respondents by their Religion

Source: Primary Data

Educational Background of the Respondents: This refers to the number of years of school they have attended or finished. Education might have an impact on depression, respondents were established by evaluating their education. Lower grade level of education, and co-occurring depression and anxiety can also exacerbate this association. Depression has also been linked dropping out of school (Ibrahim et al., 2017). Above half (53.7%) of respondents attended secondary school and 46.3% attended elementary school. Overall, many respondents had secondary and primary education. The level of education is related to the degree of knowledge of depressive disorders among orphans because education impacts the wellbeing of individuals or communities as a whole.

Income Level of the Respondents: The monthly income of the head of the family includes all sources of income. The overall development of the children's families depends on their family income. The results revealed that, 33.3% of the respondents have no income and relied on the safety net program, while 36.5% has an income of less than 758 Birr (National Currency). However, 14% of the sample orphans did not know their families' monthly income, while 1.4% said their income is greater than or equal to 2151 Birr. This suggests that the majority of responders had extremely poor income level, due to that they placed their kids in orphanages. People in lower-income neighborhoods are more susceptible to depression (Mutiso and Mutie, 2019).

***Distribution of Respondents by their Parents' Occupation*:** Occupation will show the status of the orphans' family status and their economic condition. Concerning sample orphan families' head occupational status, majority (68.1%) is unemployed, 9.7% daily laborers, and 5% government employees, 8.6% self-employed, and 7.9% retired. According to this finding, more than half of orphan families are unemployed; this may affect the outcome of depressive disorders negatively.

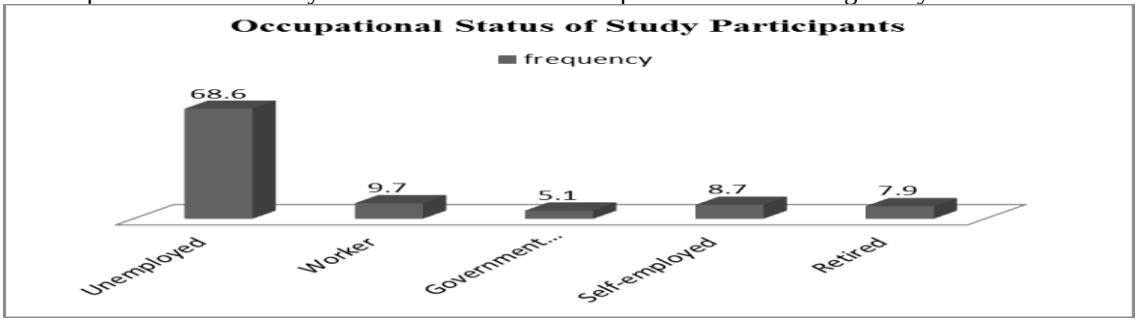

Figure 3: Distributions of Respondents by their Parents' Occupational Status

Source: Primary data

Distribution of Respondents by Residential house Ownership: House ownership among orphan families is crucial because, housing instability is one of the causes of depression. According to this survey, 13.3% previously lived with their foster parents or other relatives before entering the orphanage, whereas 82.8% of the respondents do not own their own house and reside in rented house. However, 3.6% of the respondents said they lived in their own home. It may be inferred from this that the majority of responders' families have no house and are underprivileged. Research shows that home ownership is eventually linked to a reduction in depressive symptoms (Haile et al., 2019).

Distribution of Respondents on the basis of having biological relatives: A person's blood relations, as opposed to those they have gained through marriage, adoption, or fostering, are referred to as their biological relatives. Being biologically related to someone is a significant socio demographic factor because it affects how orphans receive psychological assistance. Assessment results show that, 62% of respondents have biological relations while 36.6% don't have. Most orphans have family members, which is crucial if they visit their relatives.

6.2. Prevalence of depression

Millions of African children are growing up under harsh and adverse psychosocial conditions characterized by chronic war trauma, chronic poverty, HIV infection, orphan hood, child abuse and neglect, food insecurity and famine but it's not fully known how these conditions negatively impact on childhood mental health including how they predispose to childhood depression (Lim et al., 2020).

Depression is a disorder that is defined by certain emotional, behavioral, and thought patterns. According to this study, the prevalence of depression among orphan adolescents is 28.5%; among this female (58%) have a higher prevalence of depression than males (42%). The current prevalence is in line with the study done in Addis Ababa (25.3%), Ilu Abba Bor Zone (24.1%), and Nepal (33.2%) (Bhatt KB et al., 2019).

In addition, the prevalence in sub-Saharan African countries (7.6–34.7%) is consistent with the range of studies conducted in Ethiopia (25.3–34.7%) (Shiferaw, G., et al., 2018). This result, however, was higher than that of previous studies in the United States: 5.7%; Sweden: 5.8%; and Bangladesh: 15%; South Africa: 17% (Ardington, C., 2018); Egypt: 20% (Ibrahim A. et al., 2019); and Uganda: 7.6% (Nakigudde et al., 2017).

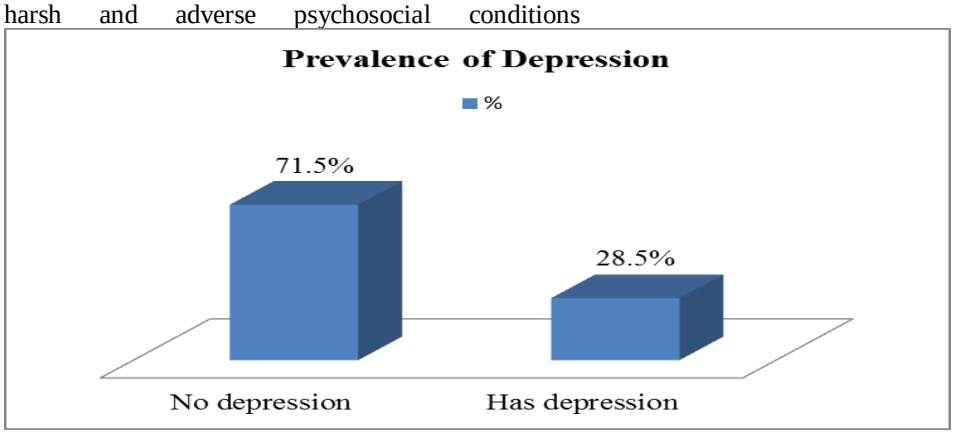

Figure 4: Prevalence of depression among sample orphan Adolescents

Source: Field Survey

6.3 Factors Associated with Prevalence of Depression

Depression is a complex disease and no one knows exactly what causes it, but it can happen for a variety of reasons. Some people have depression during a serious medical illness. Others may have depression with life changes such as a move or the death of a loved one. Still others have a family history of depression. Those who have depression and feel overwhelmed with sadness and loneliness for no known reasons (Babedi and Pillay, 2019). Orphan adolescents are a special group of people who are generally deprived and prone to the prevalence of depression among orphan adolescents was found to be high. According to different literature, low levels of social support, a longer length of stay, community discrimination, the presence of visitors, and a younger age at entrance were factors related to depression

Social Support Factors: Social support refers to having friends and other people, including family, to turn in times of need or crisis to give a broader focus and a positive self-image. Social support enhances quality of life and provides a buffer against adverse life events. Among the total respondents, 59.9% had moderate social support, and 19.9% had poor social support. Isolation from family also plays a major role in poor social support. This is because support from a loved one can play a critical role in helping people to overcome the mental challenge, and isolation can increase a person's risk of mental health issues such as depression and anxiety (Brigitte, 2018).

Table 1: Social Support Characteristics of Orphan Adolescents.

Variable	Category	Frequency	%
Social support status of respondents	Poor social support	55	19.9
	Good social support	166	59.9
	Strong social support	56	20.2
Depression status of respondent	No depression	198	71.5
	Has depression	79	28.5

Source: Primary data

Age Factor: The number of years since a person's birth is the definition of "age" that is used most frequently. Therefore, the age of the orphan and the age at which he or she entered the orphanage were crucial factors. The respondents varied in age from ten to nineteen, with a mean age of 14.95 years and a standard deviation of 2.04 and 145.7% of the orphans are between the age of ten and fourteen and 54.3% is between the ages of fifteen and nineteen.

Chronic Disease Factor: Chronic diseases are defined broadly as conditions that last one year or more and require ongoing medical attention, limit activities of daily living, or both. Chronic diseases such as diabetes and asthma, hypertension, heart disease, HIV/AIDS, and so on are the leading causes of death and disability. Approximately half of the orphans suffered from chronic diseases, with 5.1% having asthma, 7.2% having hypertension, and 25.3% having HIV/AIDS during study time, according to their self-reports. Depression can exacerbate the pain and distress associated with physical health problems (Panigrahi, 2021).

Table 2: Health Related Problems of sample orphan Adolescents

Variable	Category	Frequency	%
Any known mental illness history	Anxiety	06	2.2
	Depression	29	10.5
	Epileptic	33	11.9
	No mental illness	209	75.5
Any chronic disease history	Diabetic	30	10.8
	Asthma	14	5.1
	Hypertension	20	7.2
	HIV/AIDS	70	25.3
	No chronic illness	143	51.6

Source: Field Survey

Duration of stay at the Orphan Centers: Duration of stay at the orphanage refers to how long an orphan stays or lives at the orphanage from the day he or she enters until the day. Orphans who stay in orphanages for a short period of time may find it difficult to adapt to their new surroundings, become less attached to the people who live there, be unable to contact their family anytime they want, and feel gloomy, leading them to believe they are alone. They may get depressed as a result of this. More than five years were spent at the orphanage by about 52.0% of the respondents. Among the total sample orphans, 62.5% did not feel discrimination from their friends and society. However, 54.9% faced physical abuse from their families and 72.2% didn't get counseling services.

Regression Analysis

As stated in the mythology, binary logistic regression analysis was carried out to identify the most influential factors of mental depression among the orphan adolescents. Logistic regression analyzes the relationship between multiple independent variables and a categorical dependent variable, and estimates the probability of occurrence of an event by fitting data to a logistic curve. Binary logistic regression is typically used when the dependent variable is dichotomous and the independent variables are either continuous or categorical. When the dependent variable is not dichotomous and is comprised of more than two categories, a multinomial logistic regression can be employed (Kleinbaum & Klein, 2010).

Variable	Category	Depression		OR WITH 95%CI		P value of AOR
		Yes	No	COR with 95% CI	AOR with 95% CI	
Educational level of Respondents	Primary school	27	101	**1**	**1**	
	Secondary and above	52	97	2.01(1.17,3.45)	1.29(0.51, 3.28)	0.596
Social support	Poor	35	20	7.16(3.04, 16.89)	4.18(1.31, 13.27)	**0.011***
	Moderate	33	133	1.01(0.47, 2.17)	1.07(0.39, 2.89)	0.901
	Strong	11	45	**1**	**1**	
Age group of	10-14 Years	14	113	**1**	**1**	

orphans	15-19 Years	65	85	6.17(3.24, 11.73)	7.78(2.95, 20.45)	**0.001****
Chronic physical disease	No	26	117	**1**	**1**	
	Yes	53	81	2.94(1.70, 5.09)	3.99(1.79, 8.90)	**0.001***
Presence of visitor	No	61	127	1.89(1.04, 3.45)	1.81(0.76, 4.27)	0.178
	Yes	18	71	**1**	**1**	
Counseling service	No	53	147	0.71(0.41, 1.25)	0.59(0.26, 1.38)	0.220
	Yes	26	51	**1**	**1**	
Facing discrimination from their friend and community	No	45	128	**1**	**1**	
	Yes	34	70	1.38(0.81, 2.35)	1.06(0.49, 2.31)	0.925
Duration of stay in orphan centers	0-5 year	67	66	11.17(5.65, 22.080)	9.22(3.90, 21.80)	**0.001****
	> 5 years	12	132	**1**	**1**	

Note: *: < 0.05 Significant; ***: < 0.001** Highly significant
Source: Field Survey

In this model, educational level of respondents, social support, age group of orphans, chronic physical disease, presence of visitors, counseling service, facing discrimination from their friends and community, duration of stay in orphan centers were the influential factors with p<0.25 in univariate analysis and in multivariate logistic regression analysis; poor social support compared with Strong social support, Age group of 15-19 years compared with 10-14 years, duration of stay 0-5 year in orphan centers compared with > 5 years and chronic physical disease were the significant factors those associated with depression among orphans.

The model results indicate that orphans who had poor social support were 4.2 more odds of being depressed as compared to those who had strong social support (AOR=4.18, p= 0.011). The possible reason stated was poor social support which may lead to increased psychological distress. Isolation from family also plays a major role in poor social support this is because support from a loved one can play a critical role in helping people overcome the mental challenge, and isolation can increase a person's risk of mental health issues such as depression and anxiety. This finding is similar to the results of study conducted in Nepal and Addis Ababa (Bhatt K B, et. al., 2020)

The age group of 15 - 19-year-old orphans had 7.8 more odds of having depression as compared to their counterparts (AOR = 7.78, p = 0.001). This is a similar finding to the study done in Addis Ababa, Ilu Abba Bor Zone (Shiferaw, G., et al., 2018). The possible reason might be that orphans within this age group are more aware and conscious of their environment and lifestyle as compared to orphans within the age group of 10–14 years. This leads to getting depressed and having a poor attachment to the community.

Orphans who had the chronic disease had about 3.9 more odds of developing depression than those who were healthy (AOR = 3.99, P = 0.001). There are several ways in which major depression and physical health issues interact. The possible reason is that depression can exacerbate the pain and distress associated with physical health problems. It also might be functional impairments or disabilities related to a chronic physical disease that greatly increase the risk of depression among those with chronic physical health problems. Major depression is linked with poorer self-management of chronic physical health problems, which increase the burden of the disease. The number of different types of pain a person experiences is directly proportional to the prevalence of depression. This finding is supported by the studies conducted in Nepal and Cambodia (Mutiso DN et.al, 2018).

Duration of stay within 0-5 years in orphan centers can contribute 9.2 times more odds of depression than those who stay longer than 5 years. (AOR= 9.22, p=0. 001). This result is supported by other studies done in Dhaka and Ilu Abba Bor Zone (Shiferaw et al.2018). The possible reason might be orphans who stay a small duration of time within the orphans' center might get difficulty to adapt the environment, less attached with the people who lived in the center, they cannot get their family whenever they want, and they will be hopeless so they may think themselves lonely and might lead them to be depressed.

6.4 Outcome of Depression Disorder

Most people feel sad or low at some point in their lives. But clinical depression is marked by a depressed mood most of the day, sometimes particularly in the morning, a loss of interest in normal activities, and relationship symptoms that are present every day for at least 2 weeks. Untreated depression increases the chance of risky behaviors such as drug or alcohol addiction. It can also ruin relationships, cause problems at work, and make it difficult to overcome serious illnesses. Depression carries a high risk of suicide. This is the worst, but very real, outcome of untreated depression (UNICEF, 2019). According to this study, in the past year 3.9% attempted suicide, 15.7% engaged in unsafe sexual practices, 31.4% decreased their school attendance and performance, 24.1% felt failure, and 38.2% lost their appetite. About 92.4% of the respondents had no history of substance use within the center, 62.5% did not feel discrimination from their friends and

society. However, 54.9% faced physical abuse from their families.

Table 4: Depression Related Outcome among Sample Orphan Adolescents

Variable	Category	Frequency	Percentage
Suicide attempted in the past year	Yes	11	3.9
	No	266	96.1
Unsafe sexual practices	Yes	16	5.7
	No	261	271.3
School's performance declining	Yes	87	31.4
	No	190	68.6
Feeling that everything you have done has been a failure	Yes	67	24.1
	No	210	75.9
Having Poor appetite	Yes	106	38.2
	No	171	61.8
Facing physical abuse or violence in the family	Yes	152	54.9
	No	125	45.1
The feeling of discrimination from friends and society	Yes	104	37.5
	No	173	62.5
Substance use of alcohol	Yes	21	7.6
	No	256	92.4

Source: Field Survey

6.5 Depression Disorder Prevention and Treatment Practice at Orphan Centers

Clinical depression, also known as major depression, is an illness that involves the body, mood, and thoughts. Major depression affects the way we eat and sleep and it affects the way we feel about ourself and those around us. It even affects our thoughts. People who are depressed cannot simply "pull themselves together" and be cured. Without proper treatment, including antidepressants and/or psychotherapy, untreated clinical depression can last for weeks, months, or years. Appropriate treatment, however, can help most people with depression. More than 80% of people with clinical depression can be successfully treated with early recognition, intervention, and support (Abhishek et al., 2017).

Nine orphan centers were chosen for this study, but only two of them had a psychiatric clinic and a depression prevention activity practice. As shown in Table 5, 18% of the respondents participated in health education sessions, 11.1% participated in health education with audiovisual material, and only 18% received health education in their native language. One center had a social worker who provided social support and 72.2% orphans didn't get counseling services.

Table 5: Depression disorder prevention and treatment practice at orphan centers

Variable	Category	Frequency	Percentage
Health education session regarding depression at the orphanage center	Yes	50	18
	No	227	82
During health education, do you use audiovisual material	Yes	31	11.1
	No	246	88.9
Is local language used for health education?	Yes	50	18
	No	227	82
Bi-annual depression screening program for all orphans to take prevention measures	Yes	40	14.4
	No	237	85.6
Psychiatric clinic providing training	Yes	20	7.2
	No	257	92.8
Social worker at your orphan center	Yes	17	6.2
	No	260	93.8
Psychiatric treatment clinic at the orphan center	Yes	48	17
	No	229	83
Functional depression treatment service according to standard (manpower and medication)	Yes	40	14
	No	237	86
Counseling service	Yes	77	27.8
	No	200	72.2

Source: Field Survey

7. Conclusion and Recommendation

In conclusion, the depression level among orphans was not that much high. Poor social support, having a chronic disease, the orphans' age group, and the length of stay in orphanages were the factors associated with depression. This study suggests that steps should be taken to reintegrate orphans into the community because they faced poor social support, to ensure the provision of psychiatric care within the centers, and to decrease social isolation. Orphans in the age range of 15–19 who are diagnosed with a chronic physical disease and those who stay in the centers for less than 5 years need close follow-up and attention. As a result, the orphans' center must collaborate with other organizations to provide proper psychiatric services to diagnose and treat depressed orphans. Depression has no single cause, which means it needs integrated work to solve the problem. Based on the findings, following recommendations are forwarded for the responsible bodies.

- The orphan's administrator, in collaboration with staff, must monitor and pay close attention to orphans aged 15 to 19, those who have lost both parents through death, those who have been diagnosed with chronic physical disease, and those who have been in the centers for less than 5 years.
- Actors in the Health Bureau Administration might be involved in the provision and monitoring of improving the service that orphans get for adequate health care, especially psychiatric care. It should also provide training and awareness about the mental health problem and ways to diagnose and treat it well for staff who works in the orphan centers, especially for health professionals who work in the centers.
- Non-governmental organizations shall work to provide better service for those orphans who lost their parents by giving psychological support and showing love to minimize the feeling of loneliness. It will also be better if they try to fund orphan centers to get psychiatry services for orphans.
- It will be better if researchers conduct studies specifically focusing on those orphans who have been diagnosed with chronic physical diseases to clearly identify the relationship between chronic physical diseases and depression in orphans.

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