The Roles and Challenges of Household Care Giving in Child Headed Households Affected by HIV/AIDS: ***the case of 10 child household heads in Addis Ababa***

by

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Declaration

I declare that '*The Roles and Challenges of Household Care Giving in Child Headed Households Affected by HIV/AIDS: the case of 10 child household heads in Addis Ababa'* is my work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

---------- 31/03/10
SIGNATURE DATE
(MR M J WOLDEYOHANNES)

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The greatest contribution of this work has come from my supervisor, Dr. ME Rabe. Quite simply without her support, this work could not be. She managed to find the balance between my need for freedom of thought and the pragmatics of sound academic writing. She appropriately criticized, praised, cajoled and restrained me.

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List of Acronyms

ACPF	African Child Policy Forum
AIDS	Acquired Immunodeficiency Syndrome
ANRS	Amhara National Regional State
ART	Anti-retroviral Treatment
BoLSA	Bureau of Social and Labour Affairs
CBO	Community Based Organization
CRC	Convention on the Rights of the Child
CRDC	Child Resource Development Centre
CSA	Central Statistics Authority
ETB	Ethiopian Birr (currency used in Ethiopia)
FDRE	Federal Democratic Republic of Ethiopia
HACI	Hope for African Children Initiative
HAPCO	HIV/AIDS Prevention and Control Office
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences and Research Council
IGA	Income Generating Activities
ILO	International Labour Organization
MEDAC	Ministry of Economic Development Cooperation
MoH	Ministry of Health
MoJ	Ministry of Justice
MoLSA	Ministry of Labour and Social Affairs
MYSC	Ministry of Youth, Sport and Culture
NGO	Non Governmental Organization
OVC	Orphan and Vulnerable Children
UN	United Nations
UNCHS	United Nations Centre for Human Settlement
UNCRC	United Nations Convention on the Rights of a Child
VCT	Voluntary Counselling and Testing

Abstract

Ethiopia faces large and growing numbers of child household heads, mainly due to AIDS-related parental deaths. Many of them are vulnerable to abuse and are forced to look after themselves and their siblings, drop out of school and find work.

This exploratory study employed qualitative research methods using purposive sampling. The aim was to ascertain how child household heads affected by AIDS adapted to changed life circumstances. The study entailed fieldwork for five weeks in Addis Ababa, the capital of Ethiopia, where evidence was gathered from 10 selected households headed by children (aged 12 to18), their siblings and key informants.

It was found that all the children in the study are in dismal living conditions although some reported feelings of satisfaction and happiness. The need to provide special recognition and support to child household heads and their siblings by policy makers and service providers in Ethiopia is highlighted.

Key Words

HIV, AIDS, Household, Child, Orphan, Child-Headed Household, Care Giving, Siblings, Addis Ababa.

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Chapter One: Introduction

1.1. Background and Purpose of the Research

Research in common parlance refers to a search for knowledge. One can also define research as a scientific and systematic search for pertinent information on a specific topic. Some people consider research as a movement from the 'known' to the 'unknown'. It is actually a voyage of discovery from *identification of research problems* to dissemination of research findings (Kothari 2004: 15-68). Identification of a research problem basically involves choosing a research topic, but the motivational factors that intrigued researchers - for example, by their own life experiences and *observations* - in the first place could be one good reason for identifying a research problem (Dooley 1995; Giddens 1996; Mann 1976; Moore 2001).

The research problem of this particular study has been formulated in response to the growing number of unaccompanied child household heads who received the care and support services under the category of orphan and vulnerable children (OVC) from an organization[1] working in the fields of HIV/AIDS in Addis Ababa, the capital of Ethiopia. At this organisation 220 unaccompanied child household heads were listed – with an average household size of 2.1 – as receiving support from this organization[2]. Girl-child heads constitute 47% of the 220 child household heads. The majority (64%) of these 220 child household heads is between the ages of 12 and 18. This figure may be indicative of the large number of unaccompanied child household heads – due to AIDS-related parental deaths – in the country[3]. However low or high the figure might be, no one can underestimate the severe

[1] The organisation is called Hiwot HIV/AIDS Prevention, Care and Support Organization (HAPCSO). I have been working for the last four years in the capacity of Monitoring and Evaluation Specialist in this organization. A profile of the organisation is available at: www.hapcso.org.
[2] I have the list of these households.
[3] It would be impossible to estimate the national figures on child headed households given the limited geographical coverage of my current work place organization.

impact of AIDS-related parental deaths on the lives of children and its threat to Ethiopia's long term developmental endeavours.

The growing number of child household heads with their unique needs and challenges – as experienced in my current work place organisation – has been such an unprecedented phenomenon that it triggered the following research question: *How child household heads in Addis Ababa, Ethiopia, who lost their parents to AIDS, cope with the challenges of caring for themselves, their younger siblings and preparing for their future?*

In my view, child household heads are a special group, even within the category of orphan and vulnerable children, with their own unique needs and challenges. Due to their limited physical and emotional maturity, child household heads find it hard to earn a satisfactory living with little or no support from extended family members. Yet they are sidelined by policy makers, advocacy groups, service providers and the community due to different factors, including the lack of research on the subject. Hence, I found merit in exploring the roles and challenges of child household heads affected by AIDS in household care giving efforts. This study would contribute to an understanding of the reality of experiences and reflect on the complexities in the lives of these children as heads of households.

This study is exploratory in nature and it employed qualitative research methods with a purposive sampling technique. The aim was to ascertain how child household heads affected by AIDS adapted, what certain events meant to them, how they viewed what had happened to them and how their life circumstances changed. The study entailed fieldwork for five weeks in Addis Ababa, the capital of Ethiopia, where evidence was gathered from 10 selected households headed by children between the ages of 12 to18, their siblings and key informants using different qualitative data collection methods.

Beyond its academic purpose[4], I hope that this study would aid in solving the multifarious problems (such as developmental, socioeconomic and psychological problems) of child household heads affected by AIDS in Ethiopia. This could be achieved, for example, by presenting the results of the research to the service providers[5], advocacy groups and policy makers in order for them to understand and take appropriate action to solve the problems of these households.

1.2. Situating the problem

Two paradoxical issues have become primal concerns for growth and development in Africa today: the growing importance of youth in economic and social development on the one hand, and the damaging effects and consequences of HIV and AIDS on the youth on the other. These damaging effects of HIV and AIDS include the capacity of child household heads to care for themselves, their siblings and planning for the future.

The youth constitutes the largest proportion of the African population. The UN in one of its earlier reports indicated that Africa's population growth rate was 2.4% compared to a global population growth rate of 1.3% (United Nations 1998). Looking at the current world population's growth rate, no marked difference is found in Africa (Africa's population growth rate is still 2.4%) despite a slight decrease in the world population growth rate (1.2%) (UN Report 2008a). This growth in population 'mean[s] that the distribution of the population is heavily skewed towards younger people' (Durham 2000:114), which highlights the growing importance and participation of the youth in the socioeconomic development endeavours of nations in Africa. Equally important is that these young populations in Africa are threatened by the HIV and AIDS epidemic that hit the continent by being victims from HIV related infections as well as facing the consequences of the illness, including the death of parents. According to a recent estimate, for example, sub-Saharan

[4] Achievement in careerism (completion of my post graduate study) is in fact the first benefit in which outcome of this particular research will bring about. Above all, it will also lay a fruitful ground for me in my journey to a Doctoral study.

[5] For example, I have an opportunity to present the real picture of the study to the organization where I am currently working so that the organisation can take the issue of child household heads as part of its main strategy.

Africa continues to be the region most affected by the AIDS epidemic. More than two out of three (68%) adults (15-49 years of age) and nearly 90% of children (less than 15 years) infected with HIV live in this region, and more than three in four (76%) AIDS-related deaths in 2007 occurred in this region (UNAIDS/WHO 2007:7).

The AIDS epidemic has many and various problems such as posing a severe threat to child development. However, the children affected by the epidemic, especially those *indirectly* affected through the sickness and death of parents, guardians and siblings and others in the community, have not been seen as a priority (Save the Children- Denmark 2005: 3). This growing cohort of vulnerable children, too often forgotten, will have an all pervasive effect on society.

The world thus far faces an estimated 13.4 million orphaned children due to AIDS-related parental deaths. Out of this number sub-Saharan Africa is home for an estimated 12 million children who lost their parents due to AIDS-related deaths (UNICEF 2007:24). By the year 2010, an estimated 15 million children under the age of 18 in Africa will have lost one or both parents due to AIDS (UNICEF 2005). The growing pressure the AIDS epidemic exerts on both household and community is shown by the increase in elderly caregivers and child headed households in severely affected African and Asian countries. There are generations of children in Africa whose development is being challenged due to the results of the AIDS epidemic. The decline in standards of living for young children is clear evidence of this. This phenomenon partly exerts pressure on the already fragile services provided by the state and community.

In view of these realities, this research sought to explore how child household heads in Ethiopia, due to the loss of their parents to AIDS, were coping with the challenges that they faced such as caring for themselves, their younger siblings and preparing for their future. This research also attempted to examine the existing support mechanisms that were available in order to assist these households in coping with the challenges they have faced.

These following issues were addressed in this particular research by the following main and subsidiary research questions:

1.3. Research Questions

1.3.1. Main Research Question

How child household heads between the ages of 12 to18[6] *in Addis Ababa, Ethiopia, who lost their parents to AIDS, cope with the challenges of caring for themselves, their younger siblings and preparing for their future?*

1.3.2. Subsidiary Research Questions

- What are the social, economic and developmental challenges that child household heads face when taking on the role of parents at an early age (both before and after the death of parents)?
- Do child household heads assume full adult roles as household heads, or do they try to fulfil their needs, desires, and aspirations associated with youth?
- What is the nature and level of conflict and cooperation that exists between the child household heads and their younger siblings?
- What support mechanisms and other networks exist in order to assist child household heads and their siblings?

1.4. Research Objectives

The study gathered evidence on the roles and challenges of child household heads whose parents died from AIDS-related illnesses in Addis Ababa. The aim is to present the findings of this investigation to relevant people in order to inform policy, advocacy and programmatic interventions. Specifically, the study focused on exploring:

- The economic, social and developmental challenges faced by child

[6] At the time of this study, this age group has been the majority (accounted for 64%) of the 220 child household heads who received support from my current work place organization.

headed households affected by AIDS.

- The coping mechanisms that are adopted by child household heads in order to address the challenges associated with performing parental roles.
- The relation of authority that exists between household heads and their younger siblings.
- The support mechanisms that exist for child headed households affected by AIDS in Addis Ababa.

1.5. Operational Definitions

Child refers to a person who is under 18 years of age, but for the purpose of this study between 12 – 18 years of age (MYSC 2004). Also, the terms child and adolescent are used interchangeably in this study since the main target of this research has been children between 12-18 years who are considered adolescents (Cardwell, Clark and Meldrum 2000; Erikson 1968).

Child Household Heads: In this particular study, child household heads are defined in terms of age and role based categories. In terms of age based category, a child referred to a person between 12-18 years. Child household heads– in relation to a role category – has been defined as boy or a girl who was living with his/her siblings and became the sole breadwinner to the household. The child could either be school-going or a school drop-out and employed either in casual or permanent work to provide for his/her household. The child has taken household care giving responsibilities because both parents have passed away (at least one parent died due to AIDS) (ACPF 2008).

Household refers commonly to 'a person or group of related or unrelated persons who lived together in the same dwelling unit(s) or connected premises who acknowledge one adult member [including a child between 12-18 years] as head of the household and who have common arrangements for cooking and eating meals'(CSA 2006a). In terms of its composition, this study has taken a household as being headed by a child between 12-18

years, composed of at least one or more members/siblings less than 18 years of age in the same dwelling unit.

Orphan refers to a child less than 18 years of age without parents. In this study orphan refers to a double orphan whose parents have died from any cause but AIDS was the cause of death for either one or both parents of the orphan child (UNICEF 2006).

1.6. Problem Statement

The first reports of large numbers of child headed households appeared in the early nineties in Uganda and later on in Tanzania, Zambia and Zimbabwe, where the AIDS epidemic started to develop. Now, a few years later, the problem seems to pervade nearly all countries of the African continent. Partial estimates put the figure of child headed households as high as 3% of all households in Zimbabwe, 7% in Zambia and 13% in Rwanda (UNICEF 2006). Some recent statistical evidence puts Ethiopia as one of the countries with the highest percentages of child headed households in Africa. A 2005 survey showed an estimated 522 000 children living in child headed households with no accompanying adults (CSA 2006a). Others estimate that there were 77 000 unaccompanied child household heads in Ethiopia in 2005 (ACPF 2008). Given the growing number of children orphaned by AIDS, a sharp rise in the number of child headed households in Ethiopia is expected. Little in-depth data is available on the causes, consequences and extent of the phenomenon. Most of the information on child headed households in Ethiopia was embedded in the literature relating to orphans and vulnerable children in general. The lack of the information available on the subject masked the specific nature of the challenges facing child headed households, as well as the special support they need, and their plight has not been sufficiently appreciated by the state, service providers and the community. This phenomenon is new and even perplexing to policy makers, service providers, social scientists and the community because it poses enormous unknown challenges to existing modalities of social protection and legislative action.

Much has been said about the plight of orphan children in the world and in Africa as well, but the concern to recognise child household heads as a special group is less common despite significant differences that exist between child household heads and orphan children who are cared for by grandparents or other extended family members. This lack of concern impedes the needed urgent attention to child household heads. The main difference between orphans in general and child heads of households in particular is that the latter do not and cannot rely on adult care, guidance and protection, and do not receive strong family support. The child is left on her/his own and is responsible for sustaining the family with both material and emotional support. Those child headed households that do exist can be expected to have greater needs and vulnerabilities than households headed by an adult and may also be less able to earn sufficient money, protect themselves, deal with the legal system or make good decisions in their day to day lives (UNICEF 2005: 17). This problem necessitates an in depth investigation mainly to understand and ascertain the *underlying causes* and *challenges* of child household heads affected by AIDS in household care giving efforts. These main concerns of this study will be discussed in further detail below.

Equally important is that child household heads and their siblings have been given little attention in studies, policies and support interventions. For example, studies on youth or younger children focus on 'deviance or of problems needing programmatic intervention' (Durham 2000:116) leaving aside the importance and productive role of the youth in a society. Yet despite growing interest globally and in Africa specifically on child household heads and their well being, this group as a category has been overlooked in policies about how to support and understand the effects of HIV/AIDS on households. The focus of the HIV/AIDS intervention programmatic areas of some agencies is clear evidence of this. For example, UNICEF/UNAIDS/USAID (2004:3) promote that 'programs should not single out children orphaned by AIDS but should direct their efforts toward communities where HIV/AIDS is making children and adolescents more vulnerable' for reasons of orphaning is not the only way that children may be affected by HIV/AIDS. This leaves the growing numbers of child household heads affected by AIDS in a general category. However, it is

becoming evident that policies and strategies that deal with child household heads—as a special category from orphan and vulnerable children and/or grandparents—are needed.

Thus, this research addressed the neglected area of child household heads affected by AIDS, and aimed to fill a gap in the hope that it would contribute to interventions and planning support mechanisms.

1.7. Limitations of the Research

Time constraints were an apparent limitation of the study. Because the qualitative method selected needed a deeper understanding of issues, more time to acquire the desired information from the respondents would have added depth and richness to the study. However, since I had prior knowledge of the research area and the research targets[7], I could manage the fieldwork within the assigned time frame.

Moreover, time constraints were apparent not only from my side but also from respondents that were requested to spend a big share of their time with me which clashed with their personal and household responsibilities and priorities. But, to address this problem meeting times for the interviews had been arranged in their leisure time, mostly on Sundays and after 5:00 PM on weekdays.

There were also apparent limitations emanating from the very nature of the research method, i.e., the small sample drawn with a purposive sampling method. The total number of research participants was not intended to show a universal societal reality and way of life as generalizations to the broader population cannot be made from this research. All the participants are persons in their own right rather than representatives of all the children heading a household in the country. However, it is my belief that this problem of a small number of research participants is balanced by the depth of exploration and flexibility that

[7] I have previous experience in undertaking evaluation research to measure the impact of intervention programmes implemented by my current work place organisation in collaboration with different international non-governmental organisations. While conducting such studies, the proposed research strategy of this particular research has been used frequently.

the method allows. However, I believe that the stories of the children in this study give rich information in terms of life experiences and choices made by the different heads.

1.8. Outline of the dissertation

This dissertation is organised into six chapters. **Chapter One** deals with the introductory part of the paper including the background and purpose of the research, stating the problem and problem statement, research questions and objectives of the study. **Chapter Two** highlights concepts and the theoretical approach. In discussing the relevant concepts, efforts are made to review the explanations and definitions that are given for the six important concepts: 'child', 'household', 'orphan', 'HIV/AIDS', 'child household head' and 'poverty and being an orphan'. In the theoretical approach section theories on child development focusing on children between 12-18 years is discussed. More specifically, the psychosocial theory on child development as described by Erik Erikson together with the debate over the issue of adolescence in the African context form the central theoretical orientation point for this study. **Chapter Three** reviews the available literature on the impact of HIV/AIDS on child household heads and the social support mechanisms that are available to address the challenges of these households. In **Chapter Four** the research methodology employed for the research is outlined. **Chapter Five** focuses on the data analysis and interpretation that are gathered from the field study. **Chapter Six** centres on conclusions and recommendations based on the analysis and the general content of the study. The interview guides and informed consent forms are available in the addenda of this study.

Chapter Two: Concepts and Theoretical Approach

This chapter highlights the concepts and theoretical approach believed to be pertinent to the particular topic of this study.

2.1. Concepts

This section centres on the four significant concepts of this study namely c*hild, orphan, household* and *HIV/AIDS*. Also, further aspects, namely *poverty and being an orphan* and *child headed households* are discussed. The aim of this discussion is to clarify the use of these salient concepts in the study.

2.1.1. Child

The concept child is central to this specific study because the main target group falls under the category of 'children'. The demarcation lines between 'child', 'youth' and 'adult' are difficult to apply universally since almost all societies have their own conception of what these categories mean and the attributes assigned to them. The definition of child is socially constructed and therefore its meaning varies from one society to another at different times in history.

There is an age based category demarcation used by different development bodies like the UN, ILO and member states that ratify the UNCRC. The most widely used definition currently is the one which is adopted by the UN for the formulation of the CRC and it is used as an official standard definition throughout the world. It defines the term 'child' as 'every human being below the age of 18 years unless, under the law applicable, majority is attained earlier' (UN 1998, Article 1). When using this definition it does not mean that it will apply to all communities in the world in the same way, but as it is accepted by many nations in the world, it will have a significant implication on policies and intervention strategies that focus on children.

Similarly, there is no uniformity in the definition of child in Ethiopia as it varies 'depending on the existing economic, social, cultural and political setup and life style' in different parts of the country (MYSC 2004:3). Consequently, the Ethiopian Youth Policy, taking into consideration the different perceptions, the existing conditions and realities in the country, defines 'those members of the society less than 18 years as children' (Ibid.).

2.1.2. Orphan

The concept orphan is important for this research because the central concern is to try and identify the challenges faced and coping mechanisms adopted by households headed by children who lost their parents due to AIDS.

According to Geldard and Geldard (2002:88), 'orphan' is a socially constructed concept of which the meaning and content vary between cultures and countries. For example, in some cultures it refers to children who have lost one parent, while in other cultures the term is reserved for children who have lost both parents. For example, according to a situational analysis of orphans and vulnerable children in four districts of South Africa, there are two terms that describe an orphan in a Setswana district: 'lesiela' (lost one parent), and 'kbutsana' (lost both parents). The former is widely used because it is user-friendly and less derogatory, while for the latter there is the implication that the child has absolutely nobody, which is contrary to extended family norms (Skinner et al 2004:9).

A similar division has been made by different development bodies to identify different kinds of orphans mainly for statistical purposes in estimating orphan sub populations and formulating policy documents. For example, an orphan is defined by UNAIDS as a child *under 15 years of age* who has lost his/her mother ('maternal orphan') or both parents ('double orphan') to AIDS (UNICEF/UNAIDS 1999). In other definitions the age of orphans is increased to children *under the age to 18 years*, e.g.: the Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS uses the following definition for an orphan: 'an orphan is a child under 18 years of age whose mother, father or both parents have died from any cause'. An orphan, can be more specifically described as a single orphan (a child who has lost one parent), a

double orphan (a child who has lost both parents), a maternal orphan (a child whose mother has died) and a paternal orphan (a child whose father has died) (UNICEF 2006:4). There are thus significant differences in defining the concept orphan and it is important to note that this study specifically focuses on children who are double orphans.

These categorizations can serve as an indicator for the level of challenges that children and households might face based on their status of being an orphan. There are indications that double orphans, compared to single orphans, are more vulnerable to challenges in their life. For example, it became evident that double orphans are more prone to be excluded from essential social services, such as education (UNAIDS/UNICEF 2004).

2.1.3. HIV/AIDS

Conceptualizing HIV/AIDS in this particular research is equally important since the study focuses on the roles and challenges of household care giving in child household heads affected by AIDS.

HIV/AIDS is as much about the social aspects as it is about biological concerns. Mann (quoted in Brennan and Rankin 2004:1) identified three phases of the HIV/AIDS epidemic: the epidemic of HIV, the epidemic of AIDS, and the epidemic of stigma, discrimination and denial. The first two phases are related to the biological/epidemiological nature of the disease, while the final phase relates to be the social constructs given for the disease.

The social construction of the disease is such that it is associated with stigma, ostracism, repression and discrimination as people with HIV or AIDS and their families have been rejected by their communities in different social settings. The rejection holds as true in the rich countries of the north as it does in the poorer and developing countries of the south due to differing social speculations and misconceived notions people have about HIV/AIDS. Early speculations of HIV/AIDS, which suggest that it is a ‘woman’s disease’, a ‘junkie’s disease’, a ‘black disease’, an ‘American disease’ or a ‘gay plague’ are clear evidence of this. Some of these speculations are still rampant in many parts of the world. In fact, these speculations do not arise out of the blue, nor is something dreamed up in the minds of

individuals. Instead, like responses to diseases such as leprosy, cholera and polio in the past, it reflects deep-rooted social fears and anxieties (Loeing-Voysey and Wilson 2001).

Also, such speculations and constructs build upon and reinforce earlier negative notions. People with HIV/AIDS are often believed to have deserved what has happened by doing something wrong. Often these 'wrongdoings' are linked to sex and socially frowned-upon activities, such as intravenous drug use. Men who become infected may be seen as homosexual, bisexual or as having had sex with prostitutes. Women with HIV/AIDS are viewed as having been 'promiscuous' or as having been sex workers (Weeks 1981). The spread of HIV has been associated with female sexual behaviour that is not consistent with gender norms. For example, in most African countries, prostitution is widely perceived as non-normative female behaviour, and female sex workers are often identified as 'vectors' of infection who put their clients and their clients' sexual partners at risk (Aggleton and Warwick 1999). This is especially true in settings where heterosexual transmission is significant.

Like many other sexually transmitted infections, HIV/AIDS was first perceived as a disease of 'outsiders' (Gilman 1998). In the early 1980s, for example, among gay and other homosexually active men in Europe and Australia, it was seen as being closely linked with the United States of America (the 'outsiders' in this case). In the eyes of some African and Asian leaders, HIV/AIDS has been viewed as a disease of the West, linked to the weakness of family structures, liberal social values and moral decline (Brennan and Rankin 2004). With the passage of time, and for diverse reasons, in most countries of the world, AIDS has come to be associated with sub-Saharan Africa.

The social speculations associated with HIV/AIDS have powerful psychological consequences for how people with HIV/AIDS come to see themselves, leading, in some cases, to depression, lack of self-worth and despair. They also undermine prevention and mitigation efforts to limit the progression of HIV and to mitigate the impact of the AIDS epidemic by making people, for example, afraid to find out whether or not they are infected,

for fear of the reactions of others. They cause those at risk of infection, and even some of those affected, to continue practising unsafe sex in the belief that behaving differently would raise suspicion about their HIV status. These misconceptions cause people with HIV/AIDS to be seen as some kind of 'problem', rather than part of the solution to contain and manage the epidemic.

To sum up – the wrong speculations stated above and other social speculations associated with HIV/AIDS have two broad social effects. First, because the social speculations about HIV/AIDS is associated with marginalized behaviour and groups, all individuals with HIV/AIDS are assumed to be from marginalized groups and some may be stigmatized in a way that they were not before. For example, in some settings, men may fear revealing their HIV status because it will be assumed that they are homosexual. Similarly, women may fear revealing their serostatus because they may be labelled as 'promiscuous' or sex workers and stigmatized as such. Second, such social speculations associated with HIV/AIDS exacerbates the stigmatization of individuals and groups who are already oppressed and marginalised, which increases their vulnerability to HIV, and which in turn causes them to be further stigmatized and marginalised.

2.1.4. Household

The concept household is important for this particular research since the research focuses on the characteristics and composition of households headed by children affected by AIDS. In the 2005 Ethiopian Demographic and Health Survey a household was defined as 'a person or group of related and unrelated persons who live together in the same dwelling unit(s) or in connected premises, who acknowledge one adult member as head of the household, and who have common arrangements for cooking and eating' (CSA 2006a: 13). Households in Ethiopia are predominantly male headed, a common feature of most African countries. More than one in five households are headed by women with the proportion of female-headed households much higher in urban than in rural areas (Ibid.: 18). The survey further illustrates that in Ethiopia, 73% of children under 18 live with both parents, 12% live with only their mother, 4% live with only their father, and 10% live with neither parent (Ibid.: 27).

Most definitions that are provided for a household are geared towards identifying households in surveys. Jenkinson (1998:4) pointed out that ideally a household 'comprises either one person living alone or a group of people, who may or may not be related, living (or staying temporarily) at the same address, with common housekeeping, who either share at least one meal a day or share common living accommodation'. Buvinic and Rao Guptha (1997: 259) define it as 'a person or a group of persons living together and sharing a common source of food'. But, Gage et al (in Buvinic and Rao Guptha 1997: 259-280) challenged the concept household by questioning its comprehensiveness and raised the concern that if the concept of a household is defined as 'those who share the same shelter, it will be difficult to incorporate those who may not always sleep in that dwelling, who live for short or prolonged periods, perhaps to find work, or to attend secondary school'. There are thus stumbling blocks in attempts to give a household a concrete definition which contributes to the confusion of defining the concept of a head of a household.

2.1.5. Child Household Heads

Conceptualising child household heads in this particular study is equally important since this research attempts to explore the roles and challenges of child household heads affected by AIDS in household care giving efforts.

Available information indicated that the concept child household head has been defined in terms of age and role based categories. For example, according to Sloth-Nielsen (2004:1) child household heads are generally considered to be those where the main caregiver is younger than 18 years of age. Similarly, a qualitative assessment of orphan and vulnerable children undertaken in two Zimbabwean districts defined child household heads as 'a household in which a person aged 18 years and below is responsible for making day-to-day decisions for a group of persons who stay or who usually reside together, share food from the same pot, whether or not they are related by blood' (Mahati et al 2004:6).

Sometimes children, who are not strictly speaking orphans, whose caregivers are terminally ill with HIV/AIDS, would be included in the category of child-headed households. When parent(s) become too sick to do what is necessary, these children assume the responsibility of heading the household. As Sloth-Nielsen (2004) puts it: 'child head households in which there is no effective adult caregiver generally do the same as parents do in the household: work to support siblings, get food, clothing and shelter, and deal with the emotional well-being of their members'. Gow & Desmond (2002:83) explained that employed adult siblings of orphans may head households. Other heads of households may be school-going older siblings, children caring for each other with adult support from another household, or children caring for a dying parent with no adult support.

Also in Ethiopia, the African Child Policy Forum (2008: 27-28) defined child household heads according to two broad categories: *accompanied child household heads* and *unaccompanied child household heads*. The former definition was related to a household where a child is providing income and care to siblings in which the parents or primary caregivers are incapacitated by chronic illness, old age or disability. The latter was given for the household where a child is supporting and taking care of siblings without an adult in the household, because both parents have died, cannot be found, are unknown or have given up supporting the children for economic reasons.

However, this particular research focuses on households headed by children – between 12-18 ages – who take care of one or more siblings (sharing a dwelling with them) with no surviving parent(s) in the household.

2.1.6. Poverty and being an orphan

Poverty contributes to the AIDS epidemic and the AIDS epidemic contributes to poverty: causation is bi-directional and occurs through many different pathways. For example, loss of labour from a farming system may result in failure to maintain infrastructure such as terracing, leading to soil erosion, and decreasing agricultural productivity (Barnett and Alen 2006). In similar vein, Stillwagon (2000: 985-1011) argued 'that HIV prevalence is highly

correlated with falling calorie consumption, falling protein consumption, and unequal distribution of income'. The epidemic can impoverish households and reduce communities' ability to sustain themselves which in turn will result in less formal education that also leads to impoverishment. That the HIV/AIDS epidemic impoverishes people, their households and communities is by now widely accepted.

But what does 'poverty and being an orphan' imply? This is the central issue to be discussed in this section but the concept *'poverty'* in itself should first be reflected upon before focusing on the living conditions of households headed by orphan children.

The concept poverty is multidimensional, which is defined by several approaches. One of these approaches is the **biological approach,** which conceptualizes poverty as the inability to meet the requirements for survival. One is defined as poor if he/she fails to meet certain basic needs, such as food, clothing and housing (Sen 1981). According to this approach, people lack the basic necessities that are needed for survival (food, water, shelter and clothing). The second approach, known as the **normative approach,** conceptualises poverty in terms of a value judgement about the minimum adequate level of welfare below which one is said to be poor. The process of defining the minimum adequate level of welfare is subjective. It depends on norms and values as they have been used over time and in a specific community and has resulted in variations on the definition of the concept of poverty (Ibid.). The **social-poverty-approach** is the third approach that views poverty as a reflection of social inequality such as lack of wealth and the absence of opportunities to exercise fundamental human rights, such as equality before the law and the right to life (Chalfant and Labeff 1988: 142-149).

Conceptualisation of poverty also differs from country to country. Categories such as 'chronic poverty' and 'mass poverty', for instance, are used to characterise poverty in developing countries. Chronic poverty refers to the state of being poor and failure to move out of it. It includes households without basic necessities for survival, with low quality of land (especially in rural areas) and insufficient productive assets, with low or no access to education, health and sanitary facilities. The main thrust of the chronic poverty argument is

that poverty is inherited and passed on from one generation to the next (Sen 1981). Poverty in Ethiopia is characterised as 'mass poverty', which is explained as a situation where the income of more than half of the total population is less than 1 US dollar a day (MEDAC 2000).

Variations on the measurement of poverty are also apparent, especially focusing on the alleged distinction among 'absolute', 'relative' and 'subjective' poverty. The definition of absolute poverty is associated with subsistence poverty. It can be defined as a situation of not having enough to get by or not having enough to meet one's needs, while relative poverty is characterised by a situation of relative deprivation that depends on the general style of living in a society. It means that basic needs may be met, but those at the very bottom have less access to other social expectations. The approach to a subjective poverty paradigm is eliciting local people's conceptions of poverty/ deprivation and to harness their own priorities in the complex and heterogeneous societies in which they live (Chambers 1995). This approach explicitly recognises that poverty is an inherently subjective judgement of individuals about what constitutes a socially acceptable, minimum standard of living in a particular society.

Explaining poverty and being an orphan can be regarded as both an easy and a difficult task. It is not an easy task as variations of the concepts of poverty and orphan still exist, which may create less certainty to provide concrete evidence on the subject. It is not a difficult task as it could be best explained from the experiences and the living conditions of orphan children. For example, it is evident that the increasing effects of the AIDS epidemic jeopardise the rights and well-being of orphan children. This is supported by studies from UNICEF (2003b:26) which states, for instance, that AIDS orphans are likely to suffer damage to their cognitive and emotional development, have less access to education and are subjected to the worst forms of child labour. Additionally, orphans run a great risk of being malnourished and growth-stunted compared to children who have parents to look after them (Confronting AIDS 1999: 223-24). A lack of schooling is often combined with a lack of proper nutrition which makes it particularly difficult for orphans to escape poverty.

What is more, the voice or real words of orphan children may tell us a lot to understand their living conditions, thereby recognising the essence of poverty and being an orphan. For example, one orphan child as reported in the recent qualitative assessment of orphans and vulnerable children in two Zimbabwean districts described the household conditions he was living in as '*Lapbe' kbaya yiyo inziki yokiblupbeka'*('our household is the centre of suffering') (Mahati et al 2006:12). From the above response, one can understand the living conditions of orphan households as painful and traumatic. This painful process is often compounded by the stigma and discrimination attached to HIV and to being an orphan. One orphan child living with HIV from South Africa described the effect:

> Even my friend told me she won't eat with me again. One told me right to my face that I've got AIDS and should stop going to school and stay at home. I would feel terrible. Cry deep down. I would sit alone and cry alone. People would be staring at you saying nothing; even those who used to be happy when they see you were not anymore (UNICEF 2005:22).

It is also evident that orphan children suffer emotionally as a result of the deprivation of parental guidance, emotional trauma as a result of loss of parents, the problem of having to cope with adult responsibilities prematurely, and vulnerable to physical and sexual abuse by neighbours and relatives.

To sum up – while the most widely used measure of poverty is the proportion of people whose income is less than 1 US dollar a day, poverty has multiple definitions and numerous ways of affecting orphan children. Orphan children experience extreme and chronic poverty (inability to move out of it) different from non-orphan children, even in poorer households (especially with caring and non-abusive parents). Orphan child poverty cannot be understood only in terms of household income, for them, poverty is experienced as both material and developmental deprivation. Such deprivation resulting from poverty is likely to have a lifelong impact.

2.2. Theoretical Approach

It is evident that HIV/AIDS has become a severe threat to children's growth and development in many ways. For example, children can be directly infected with HIV while caring for their parents with AIDS (especially if little or no precaution is being taken during care and treatment) and indirectly affected by the AIDS epidemic which claims the lives of their parents and consequently leave them as orphans. The epidemic therefore has insurmountable effects on the normal growth and development of children. As I have already mentioned, this research sought to explore how child household heads (12 -18 years), who lost their parents to AIDS, were coping with the challenges that they faced such as caring for themselves, their younger siblings and preparing for their future. This section specifically gives emphasis on theories on child development, in particular as theorized by Erikson, about this age category.

2.2.1 Erikson's developmental theory

It is widely recognised that children have to pass different stages in their normal course of growth and development. Biologically, the stage of this age group (12 -18 years) is generally considered the adolescent stage – a transitional period between childhood and adulthood. There are a number of levels on which the individual makes this transition to adulthood (e.g. social, emotional and cognitive) which does not have a clear beginning and end.

The main theme in most child development theories is that the child is presented with new conflicts at each stage of development. Erikson (1968) suggested that these conflicts were psychosocial, rather than Freud's psychosexual crises, resolving social, rather than physical, conflicts. Across the life span, Erikson identified eight crises or stages of personality development, though the fifth one (identity versus role confusion) – from age 12 to 18 – concerns this study in particular.

A crisis is a conflict, such as between independence and dependence, which needs to be resolved in order for the individual to move on to the next developmental stage of entering

adulthood. Freud (quoted in Cardwell, Clark and Meldrum 2000:495) also saw this stage – adolescence – as a 'time of identity formation'. The task for adolescents is to resolve the conflict between *identity* and role *confusion* and thus establish 'a subjective sense of an invigorating sameness and continuity' (Erikson 1968:19). In fact, prior to adolescence, the child has established a sense of identity, but this is often challenged by the physical changes and the new intellectual ability of the child (Cardwell, Clark and Meldrum 2000:495).

It is widely recognized that children at this developmental stage move from the stage of concrete operations (late childhood) to the stage of formal operations, and become capable of abstract thinking and systematic rational thought. All such changes are believed to be the positive outcomes of adolescence, which have in fact many important consequences such as 'they enable the adolescent to reach a higher level of moral development, to tackle complex and critical existing philosophical systems and to define a new identity' (Erikson 1968:128-135).

Beyond such positive outcomes however, this developmental stage has its own negative consequences, partly because the adolescent experiences role confusion. According to Erikson (1968), adolescents would use this time to adopt certain attitudes or occupations in order to decide what suited them best. In his view, this is a dominant task for this age group to a way of establishing one's own identity. To put another way, this is the period where adolescents struggle between the two extremes – the struggle between dependence and independence to seek their own personal identity.

The importance of identity lies in the way that it enables the individual to cope with the demands of life. Erikson (1968) predicted that failure to resolve the psychosocial crisis of identity versus role confusion would result in a lack of personal identity (i.e. role confusion). This may result in one of four kinds of behaviour:

- *Negative identity* - one way of coping with the failure to resolve one's identity crisis is to adopt an extreme identity, such as taking on the role of a delinquent or a drug

abuser. The individual can gain some sense of control and is asserting their independence from others, especially parents.

- *Intimacy* – the adolescent avoids being involved in close relationships because they fear losing their own fragile sense of identity. This may result in the formation of rather stereotyped relationships, or ones that are inappropriate, or the individual may prefer isolation.
- *Time perspective* - the adolescent avoids making plans for the future because such plans mean thinking about the future and the complexities of being an adult, all of which provoke feelings of anxiety.
- *Industry* – adolescents find it difficult to get their level of 'industry' right. They either compulsively overwork or they find it hard to concentrate.

Erikson's conception – similar to other psychoanalytic theories of child development on adolescence – of a distinct developmental period of adolescence has often been seen as a Westernised phenomenon. Progression from child to adult in the African context is often described as being more abrupt and marked by rituals and 'rites of passage'. Such marked differences between different cultures are important and therefore other disciplines (such as Anthropology) should also be considered. The existence of adolescence as a stage and the meanings attached to the concept is heavily influenced by the particular culture.

2.2.2 Transition into adulthood in an African context

In the case of transition into adulthood, the works of anthropologists have presented evidence that the transition from child to adult may be smooth rather than turbulent in the African context. LeVine and LeVine (1966) as reported in Sprinthall and Collins (1988:14) and Cardwell, Clark and Meldrum (2000: 497) describe a Kenyan tribe in which the transition is very abrupt – in fact, such abrupt transition is quite common in many sub-Saharan African countries. In this tribe the tasks and responsibilities of children and those of adults are rigidly differentiated. The tasks assigned to children have very low status. Only after being admitted to the ranks of adults may children be assigned the tasks and privileges reserved for adult society. The transition to adulthood is strictly marked by a ritual ceremony

– a *rite de passage*, or right of passage. In Kenya this ceremony consists of circumcision for males and clitoridectomy for females. In spite of their lack of training for adulthood, adolescents in the society are understandably eager to be permitted to undergo this rite in order to enjoy adult status. Once they have undergone the ceremony, only a brief, intensive period of '*indoctrination*' prepares them for their new roles.

In other cases, people say that 'adolescence' is not merely an artificial invention of the western' society, but it is rather the consequence of cultures that may shield people's (adults') eyes to recognise the peculiar feature of this developmental stage. In this regard, Benedict (quoted in Sprinthall and Collins 1988:15-17) surveyed information from a large number of societies to answer how the cultural differences make adolescence less credible in societies including in Africa. She concluded that the major determinant of the difficulty of recognising adolescence was the extent to which socialisation for adulthood was *discontinuous* in a society. By discontinuous Benedict 'refers to the necessity for an individual to learn a different set of behaviours, roles, and attitudes form adulthood from the set learned in childhood' (Ibid.:14). In the Kenyan society discontinuity was obviously great, since different set of expectations and status rules governed the behaviour of children and adults.

It is important to note that a long education period contributes to the concept of adolescence since it delays the entry into economic activities and other adult roles.

Now, what seems to be important is that both Erikson's conception and the debate over the issue of adolescence in the African context are based on the assumption of adults (usually parents) taking on caring roles towards children. It means that according to Erikson's conception, for example, despite being cared for by their parents, the adolescents may loose their own personal identity in a struggle between dependence and independence of themselves, especially from their parents – since this developmental stage is turbulent. Contrary to this, views from the African context illustrate that the transition from childhood

to adulthood is smooth rather than turbulent since children in Africa are given different tasks and roles as adults so that children do not experience role confusion.

Beyond these particular different views however, new and emerging challenges face most African countries in dealing with an ever growing number of child household heads – partly because of AIDS-related parental deaths –which forces us (Africans) to think differently about the notion of parenting. The enormous challenges those child household heads without any adult care face are problematic. It is evident that these household heads are likely to suffer increasing strain in their cognitive and emotional development due to various factors including the parental role they are taking on in the adolescent stage. Thus, my pragmatic stance asserts that we (Africans) had better focus on finding solutions for child household heads to cope with the enormous challenges and consequences they are facing. This is not to say that theories and debates on adolescence are unimportant, but immediate practical responses to the challenge of this inescapable reality – the ever growing number of child household heads with their own unique needs and challenges – are needed.

2.3. Summary of the Main Themes

The central c*oncepts* and the *theoretical approach* of this study have been the two main issues which I reviewed in this chapter.

With the aim to investigate the diverse challenges faced by household headed by children affected by AIDS, I have reviewed the six important concepts: child, orphan, HIV/AIDS, household, child household heads, poverty and being an orphan. Needless to say, apparent variations on the definition of each of these concepts still exist. I considered the importance of such variations but aimed to provide concise meanings for each of the concepts as it is applicable to this study.

I have also looked at Erikson's psychosocial theory on child development, with an emphasis on children between 12-18 years of age. I have examined the positive and negative outcomes of this developmental stage (adolescence) as described by Erikson. Equally important was

that I have made attempts to overview the debate over the issue of adolescence in the African context as the concept of a distinct developmental period of adolescence has often been seen as a Westernised phenomenon, with progression from child to adult in the African context being more abrupt and marked by rituals and 'rites of passage'. I argued there that both the theory and the debate over the issue of adolescence in the African context were held under the normal circumstance of parenting despite the fact that the AIDS epidemic has left sub-Saharan Africa with an ever growing number of child household heads with their own unique needs and challenges. Thus, with the belief that I am pragmatic - leaving the importance of theory as well as the debate over the issue of adolescence in the African context a side - I suggested that we (Africans) had better focus on the response to promote the well being of this unique and special group in our society.

In the following chapter I will review the impact of HIV/AIDS on child household heads together with the social support mechanisms available to assist these households.

Chapter Three: Literature Review

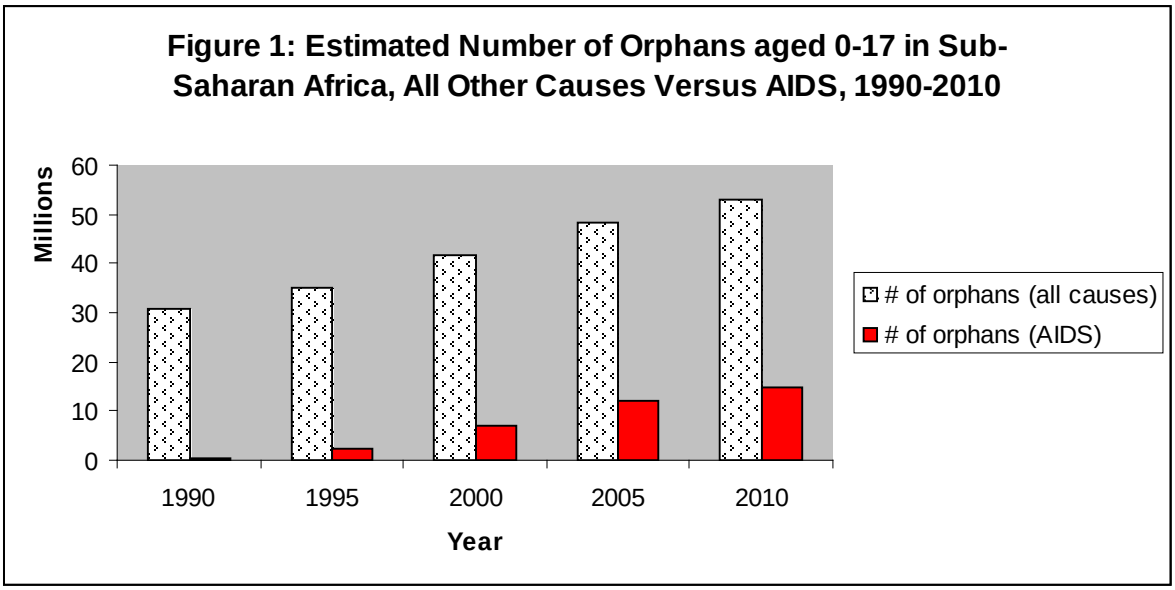
The notion of impact in the field of HIV/AIDS is often used to show the scale of the crisis the AIDS epidemic brings about in all spheres of development – including individual, household and community level. Indeed, it has been over 25 years since human beings – mostly in sub-Saharan Africa – have been suffering from the impact of HIV and the consequences of the AIDS epidemic. The effects of HIV/AIDS are numerous but this chapter specifically surveys the impact of HIV/AIDS on child household heads and the social support mechanisms that exist in response to ensure the well being of these households.

3.1 The Impact of HIV/AIDS on Child Household Heads

The *underlying causes* and *challenges* of child household heads affected by AIDS in household care giving efforts are one of the central concerns of this chapter. Before focusing on this, it is important to look at the impact of the AIDS epidemic on the trends/patterns of orphaning in sub-Saharan Africa.

3.1.1. The Impact of the AIDS-Epidemic on Trends of Orphaning in Sub-Saharan Africa

Historically, large scale orphaning has been a sporadic, short term problem caused by war, famine or disease. However, the AIDS epidemic has transformed orphaning into a long-term chronic problem that will continue at least through the first third of the twenty-first century (Hunter and Willamson 2000:1). The extensive death of adults, partly due to AIDS, in Africa is producing orphans on a scale unprecedented in world history. Without AIDS, the total number of orphans in sub-Saharan Africa would have declined between 1990 and 2010. As can been seen in figure 1, AIDS, however, will push the number of orphans in the region to more than 53 million by 2010 (UNICEF 2005).



(**Source: UNICEF 2005)**

The above figure demonstrates the impact of the AIDS epidemic that is manifested in the increasing number of orphans, especially in the time period 1995-2010. In 1990, from the total of 30 million orphans in the region, the AIDS epidemic accounted for only 1% of orphan children. However, from 1995 onwards there has been a significant increase of orphan children due to AIDS related parental deaths. The figure shows that orphan children due to AIDS related parental deaths accounted for 7%, 20% and 25% respectively of the total number of orphans in 1995, 2000 and 2005. With HIV/AIDS, if one parent is infected with HIV, there is a possibility that the other is or will become infected and that both will eventually die of AIDS. This means that there will be disproportionately large numbers of double orphans as the epidemic advances, signalling that the pattern of orphaning is shifting and the number of double orphans is increasing.

Ethiopia – similar to many countries in sub-Saharan Africa – faces the reality of a large (and growing) number of the population under the age of 18 years, accounting for 50% of an estimated population of 75.1 million in 2006 (CSA, Statistical Abstract 2007). This figure is expected to increase along with the increase in the country's population in the years to come (MYSC 2004:1). The reality that Ethiopia faces is a population with high numbers of

children and added to that the challenges of poverty, high rates of AIDS-related parental deaths and the resulting large number of *orphans.*

The AIDS epidemic is one of the leading causes of parental death in Ethiopia which leaves thousands of children orphaned. In 2003, Ethiopia attributed 539 000 of children orphaned – or 12% of the number of orphans in that year – to AIDS-related parental deaths (AIDS in Ethiopia 5th Report Fact Sheet 2003:3). In the ensuing years, this figure increased significantly to AIDS-related parental deaths accounting for 15% of orphaned children (or 744 100 from a total of 4 885 337) in Ethiopia in 2005 (Federal Ministry of Health/National HIV/AIDS Prevention and Control Office 2007:25). These figures indicate the rising numbers of AIDS orphans in Ethiopia. Additionally, some studies in Addis Ababa, the capital of Ethiopia – where this particular study has been carried out – have indicated the collapse of certain indigenous social support systems such as care from elders who are unable to withstand the financial crisis that resulted from AIDS-related mortality (Pankhrust and Hailemariam 2004: 35-58). The rising numbers of AIDS orphans coupled with the collapse of indigenous social support systems may result in a considerable number of orphans being *child household heads*.

3.1.2. Formation of Child Household Heads: Underlying Causes

In the past 25 years the AIDS epidemic has left the world, especially sub-Saharan Africa, with increasingly diverse types of household structures such as large households with unrelated fostered or orphaned children attached and cluster foster care – where a group of children is cared for formally or informally by neighbouring adult households. Today, sub-Saharan Africa faces large and growing numbers of child household heads due to HIV/AIDS and other factors such as armed conflict and grinding poverty.

It is evident that in families affected by HIV/AIDS, children start to carry the burden of being head of households even before the death of their parents in Africa. The void created by the parents (starting during their prolonged illness) precipitates the eldest child (in most cases) to take over responsibility of all household chores and the task of income-earning.

Once death occurs, traditionally, the extended family, spear-headed by aunts and uncles, is at the front line of caring for orphans, and when this link has weakened, grandparents come to the rescue. Analysis by UNICEF (2003) on caring practices in 40 countries in Africa shows that extended families have assumed responsibility for more than 90% of orphaned children.

Today, the burden of orphan care is also shifting in countries with the highest HIV prevalence levels. In Zambia, for example, female headed households are twice as likely to be taking care of double orphans compared to male headed households. In South African households that have assumed responsibility for orphans, there are on average two double orphans in each female headed household, while in male headed households the average is around one (UNICEF/UNAIDS/USAID 2004:10). In Namibia, the proportion of double orphans and single orphans (not living with a surviving parent) taken care of by grandparents rose from 44% in 1992 to 61% in 2000 (Ibid.).

These family networks will continue to be the central social welfare mechanism in most countries. However, as the number of orphans' further increases over the coming decade and an ever larger number of adults is infected and affected by HIV/AIDS, many of these family networks will face even greater burdens. In support of this, it is found that among the extended family the burden of caring for orphans or family members ailing from AIDS falls disproportionately on grandparents, many of whom suffer from poverty and poor health themselves (UNAIDS 2007:92). There is also an indication that there is 'huge variation in living conditions experienced by these children, and it still leaves millions of children being cared for by strangers – or by no one'(Ibid.:92). Hence, this traditional support system will fall under severe pressure since it is overstretched by the additional resources needed to support an ever growing number of orphans (Mahati et al 2006:2).

Now, the fact seems to be that neither new nor conventional formal and informal care systems have been able to cater to the needs of the millions (and growing number) of

orphans and vulnerable children. When all these options of care fail, children will have no choice but to establish their own household with the eldest often taking the headship.

The current thinking in Africa is still inclined towards the need of traditional (such as care by extended families) and modern mechanisms for protection of children (such as orphanages and foster homes). However, children can decide to establish child headed households, even when there are alternative care systems.

The reasons for establishing child headed households include first and foremost, these children may not want to be *separated* from their siblings and go to an *orphanage*. One study in South Africa, for example, demonstrates that child headed households are formed when brothers and sisters insist on staying together and refuse to leave their deceased parents' home (Maqoko 2006: 724). Also, research in Zimbabwe has indicated that child headed households are more frequently established if there is a child considered capable of caring for his/her siblings, or if a close relative is living nearby that can provide 'supervision' and control (UNICEF 2005:17).

Secondly, although orphanages may seem a logical solution to growing orphan populations and may also be appealing because they can provide food, clothing, and education, orphanages often fail to meet young people's emotional and psychological needs (UNICEF/UNAIDS/USAID 2004:19). This failure, and its long-term corollaries, support the conclusion of an early study in Zimbabwe that countries – and children – are better served by programmes that 'keep children with the community, surrounded by leaders and peers they know and love' (Powell et al 1994).

Thirdly, children may establish their own child headed households out of fear of being mistreated or exploited in foster families. This fear is not unsubstantiated as a study in Tanzania showed that 50% of the foster parents accepted orphans because they wanted to employ them as domestic workers (UNICEF 2006:30). There is also some evidence that orphans may experience discrimination within the household. One recent study in

Mozambique documented discrimination in allocation of resources in poor households against children who are not direct biological descendants of the household head (Ibid.: 13). Qualitative research carried out in Malawi and Lesotho found that children who had migrated to another household and also experienced the death or sickness of a parent reported being given different food from other children in the household, being beaten and overworked, and having received inadequate clothing (Ansell and Lorraine 2004:3-10). One recent study found that orphan children in Ethiopia are being ostracised by their communities and exploited financially by relatives who had taken them in (ACPF 2008). A USAID research report came to a similar conclusion: 'denied basic closeness of family life, children lack love, attention and affection - they are often harshly treated or abused by step- or foster parents' (Hunter and Williamson 2000:4).

There are also emotional or sentimental factors at work. In some rare cases, children may decide to stick together to fulfil promises to their late parents. As a result of such promises, adolescents may resist reasonable strategies for fostering, even from sincere relatives who have the orphans' best interest at heart.

To sum up – understanding the underlying causes for children to establish separate child headed households can contribute greatly in the effort to understand the current care systems in Ethiopia available to orphans.

3.1.3. Child Household Heads: Challenges and Consequences

Beyond the underlying causes however, the phenomenon of child headed households continues to give rise to a surfeit of serious short and long term consequences. Perhaps the most important is the penury of child headed households. It is evident that during the terminal stages of the illness, many households sell off property (and household items such as furniture) to raise money for hospital bills and medical treatment. Hence the resources that are badly needed for survival are depleted already, signalling the chronic impoverishment of these children even long before they are left to fend for themselves. These children start the responsibility of caring for a household and become responsible for

siblings and other family members 'when parents are debilitated by poor health' (UNAIDS 2007:92) and they will take full responsibility after the eventual death of their parents. As a result, they compare the different means to meet their survival needs: employment in hazardous work with its accompanying physical and psychological risks and exposure to various forms of slavery and prostitution; getting engaged in petty jobs; selling the family assets; and engaging in begging (UNICEF 2003a:2). Assessments by the International Labour Organization (ILO) have found that orphaned children are much more likely than non-orphans to be working in commercial agriculture, as street vendors, in domestic service and in the sex trade (UNICEF 2005: 39). Other studies have produced similar results. In the Ethiopian capital, Addis Ababa, for example, 28% of the child domestic workers interviewed in one study were orphaned (Kifle 2002:19). A study of children working – many in prostitution – in Zambia found that one third were single or double orphans (UNICEF 2005:39).

Moreover, orphans are more likely than other children to be excluded from essential social services such as education. Studies from Zimbabwe, Tanzania, and Ethiopia have found that orphans are at risk of being excluded from family care and, instead of attending school, becoming street children or victims of exploitative labour (UNAIDS/UNICEF 2004:15). Even among orphan children themselves, double orphans are more disadvantaged than single orphans. In Tanzania, the school attendance rate for children whose parents are alive and who live with at least one of them is 71%, but for double orphans it is only 52% (Ibid.).

The inability to fulfil material needs (such as household goods and money to pay for essential needs) is the one inescapable reality for households headed by orphan children. This is confirmed by recent studies in Malawi, Rwanda, Zambia and Zimbabwe where it was found that households headed by orphan children are worse off with regard to possession of basic material goods (a blanket, shoes and an extra set of clothes) compared to other children (UNICEF 2005:13). A situational analysis of orphans and vulnerable children in four districts of South Africa produced similar results where material needs were cited as

the highest priority for households with orphans, and finding the money to pay for essential needs was the greatest constraint (Davids et al 2006:ix-xi).

Apart from the material needs, the emotional and psychological problems are also evident in orphan households affected by the AIDS epidemic. Some of the experiences of orphans as heads of households include the psychological trauma of witnessing a parent's illness, of dealing with death, the absence of adult guidance and mentoring, and the unmet need for love and security (Sloth-Nielsen 2004:3). In fact, children who lose a parent to AIDS suffer loss and grief like any other orphan. However, the psychological impact on a child if a parent dies of AIDS can be more intense than for children whose parents die from more sudden causes. That is the shame, fear and rejection that often surrounds people affected by HIV/AIDS can create additional stress for and isolation of children – both before and after the death of their parent or parents. Williamson (quoted in Mahati et al 2006:2) emphasises the impact of psychosocial distress on orphan children, which include anxiety, loss of parental love and nurturance, depression, grief and separation of siblings among relatives to spread the economic cost of their care. In similar vein, a study of children orphaned by AIDS in rural Uganda documented higher levels of anxiety, depression and anger, along with inactivity, feelings of hopelessness and thoughts of suicide. In this study, 12% of orphans affirmed a wish that they were dead, while only 3% of non-orphans expressed such feelings (Benjamin, Cantor-Graae and Bajunirwe 2005: 555-564).

A set of these socioeconomic restraints coupled with the resulting agony from the loss of their parents and dealing not only with their siblings in the household, but also planning for their future, may generate anxiety in child household heads affected by AIDS. As a result, this group of children may engage in actions and behaviour that may be destructive for their households and the society as a whole. This is especially true in settings where orphan children grow up without adequate parenting and support; they are at a greater risk of developing antisocial behaviour and of being less productive members of society (Michael 2001).

The failure of parents to prepare their children during the period of their 'terminal illness' by creating alternative arrangements of living, leave the children in a 'household with limited, or no resources' (Ayieko 1997:1). Furthermore, as there is no one to perform the role of the parents properly, it may also contribute to the violent and destructive behaviour of some of these orphan children. In this kind of situation where no proper platforms are prepared, orphan children may assume parental responsibilities which disrupt their own 'normal' growth and development.

To sum up – the impact of this heavy cocktail of loss of parental psychological and moral support and love on the one hand and the inability to meet basic needs on the other hand is enormous. It manifests itself in a high level of stress due to multiple tasks beyond children's physical and emotional capacity, deterioration in their physical and psychological constitution including a decline in their health and nutritional status, and an irreversible slide into depression, fear and low self-esteem.

3.2. The Social Support Mechanisms

In many sub-Saharan countries, HIV/AIDS, in its earlier days, has been considered solely as a health problem and the social support mechanisms have overwhelmingly focused on prevention strategies. Today, the multidimensional impact of HIV/AIDS are widely recognized and governments, civil societies and others have made efforts to challenge the impact of the epidemic by setting different mechanisms in place –such as impact mitigation strategies. This section surveys the existing social support mechanisms that are available to address the challenges of orphan households. Most importantly, it investigates the role of civil society to promote the wellbeing of orphan households to cope with the challenges they face together with the legal frameworks for the protection of orphan children.

3.2.1. The role of civil society to promote the wellbeing of orphan households

'Civil society organizations' refers to a broad group of institutions and actors including, but not limited to, community based organisations, non-governmental organisations, think tanks,

social movements, religious organisations, women's rights movements, grassroots and indigenous people's movements, and voluntary organisations (UNICEF 2005:72).

Civil society organisations are bearing the heaviest load to promote the wellbeing of orphan households in many sub-Saharan African countries. In Swaziland, for example, a system of volunteers provides protection, and emotional and material support. They intervene in cases of child exploitation and sexual abuse, provide comfort to victims, consult with relatives and sometimes talk to the abusers or inform the police (Ibid.: 68). The Girl Child Network in Chitungwiza, Zambia and the Fatherhood Project in Dalbridge, South Africa have made efforts to ensure orphan children's safety and wellbeing within family care by screening and monitoring foster family placements. The aim is to prevent orphan children being mistreated or neglected (Firelight Foundation 2006:16-18). In a similar initiative, the Ethiopian Youth Forum campaigned on a variety of issues including street children, HIV/AIDS and education for girls. In 2004, the Forum was involved in a child to child survey that mapped children out of school and advocated to get them into school (UNICEF 2005:74). Because of limited space, this section examines efforts made by civil society organizations (most importantly children-focused NGOs) to address the wellbeing of OVC in general and child household heads at large in the study area, Addis Ababa.

3.2.1.1. The Role of Children-Focused NGOs to promote the wellbeing of Orphan Households in Addis Ababa

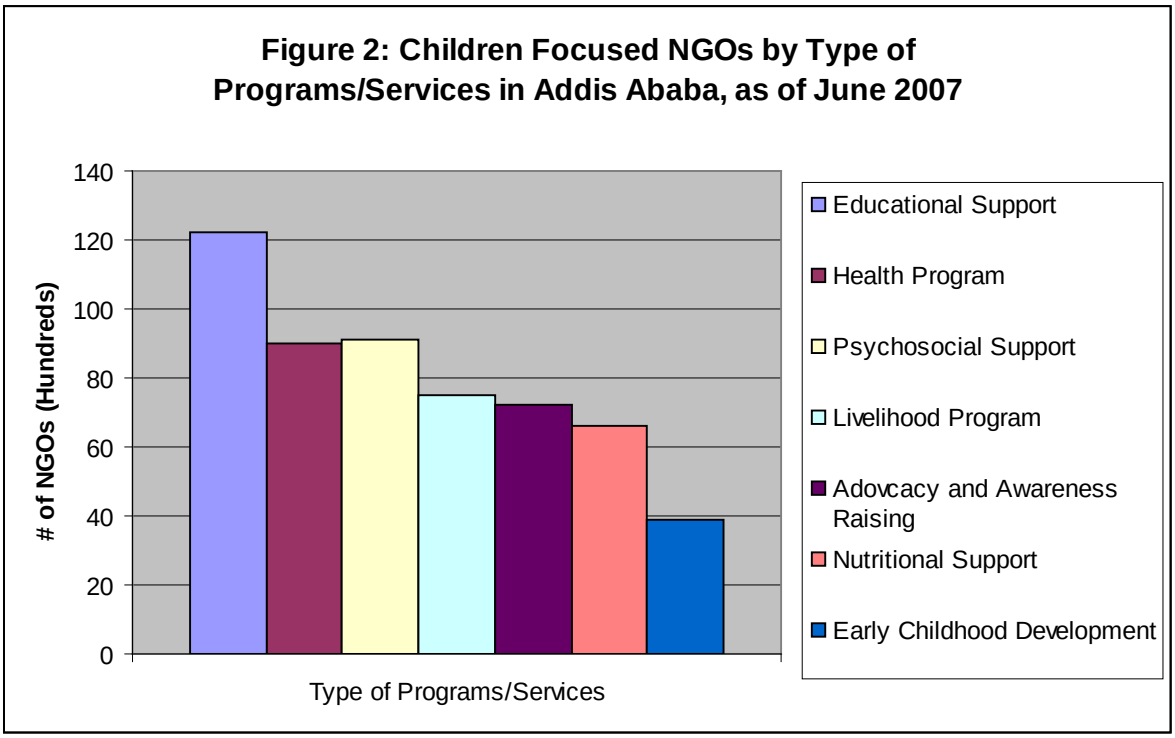
In Ethiopia, the government controls the resources allocated to OVC and vulnerable segments of society at three levels. The first level is provision of an official license to be involved in non-profit socio-economic and community development. At this level the federal and regional organs and other responsible government organisations review the capacity, structure, objectives, trustworthiness and rationale to establish NGOs. The second level is acceptance of the project or programme. At this level, the Disaster Prevention and Preparedness Commission (DPPC), a concerned government organ, appraise the project prepared by concerned NGOs and other implementers to reach an agreement (memorandum of understanding). The third level is monitoring and evaluation of implementation. The memorandum of understanding entails the implementer of the project to present progress

report to signatories (MoJ 2007). Conducting monitoring and evaluation is also part of the agreement. However, some signatory organisations do not carry out timely financial inspection, monitoring and evaluation of the implementation of the activities (ANRS-BOLSA 2008).

Available information indicated that there were 185 children-focused NGOs in Addis Ababa that have taken the initiative to provide care and support services to OVC through the home and community based approach. According to a MoJ (2007) Report, these NGOs rendered services to OVC at community grassroots in the following seven focused areas:

- Education emphasizing school fees, school uniforms and tutorial support;
- Psychosocial support such as counselling, home visits, recreational support, peer education, life skill training, succession planning and family reunification;
- Health including medicine, hygiene and sanitation, adolescence reproductive health, vaccination, VCT and ARV treatment;
- Livelihood support such as income generating activities (provision of start up capital), vocational/skill training (apprenticeship), agricultural inputs and subsistence financial support;
- Advocacy and awareness raising with an emphasis on child protection;
- Food support through the provision of supplementary food and food rations (safety net);
- Early childhood development including clothing and feeding.

As can be seen in figure 2, based on the distribution of intervention, more than three quarters (78%) of children-focused NGOs were engaged in education, psychosocial, and health related support while about two thirds (66%) of children-focused NGOs were engaged in interventions including advocacy and awareness raising, food support as well as livelihood related interventions. Only one third of organisations were involved in childhood development intervention programmes.



(**Source: Ministry of Justice 2007)**

Further evidence on the role of children-focused NGOs were scarce even when surveying the Ministry of Justice and other responsible government organs, such as HIV/AIDS Prevention and Control Office (HAPCO), Ministry of Labour and Social Affairs (MoLSA) and Bureau of Labour and Social Affairs (BoLSA). This lack of information coupled with the scanty academic studies on the roles of children-focused NGOs prevent a clear understanding of the availability, continuity and quality of the social support mechanisms rendered to assist child household heads affected by AIDS to cope with the challenges they face.

Despite such programmatic and intervention aims, an analysis made by some children-focused NGOs have presented problematic evidence on the role of children-focused NGOs in defining the concept 'orphan' and the type of support they have provided to OVC through a community based approach. For example, one recent analysis by HACI Ethiopia (2006) on Orphans and Vulnerable Children's Service and Institutional Assessment in Addis Ababa and its surroundings presented evidence on the significant differences in defining the

concept. According to the study (129 children-focused NGOs being surveyed) one out of three children-focused NGOs, or 32.6% of children-focused NGOs, had no formal definition for the concept 'orphan'. About 28.7% of the children-focused NGOs formally defined an 'orphan' as a child who has lost both parents due to death and lacked the means of meeting his or her basic needs such as food, shelter, clothing, education and care from a parent. Likewise, 32.6% of the children-focused NGOs defined an orphan as a child who has lost one or both parents. Only 1.6% of the children-focused NGOs considered a child an orphan if that child has lost one of the parents exclusively due to the AIDS epidemic (HACI 2006:10). In almost all the cases, children-focused NGOs have an expanded definition of orphan beyond simply the death of parents. These definitions incorporate the concept of basic needs and social protection required by children.

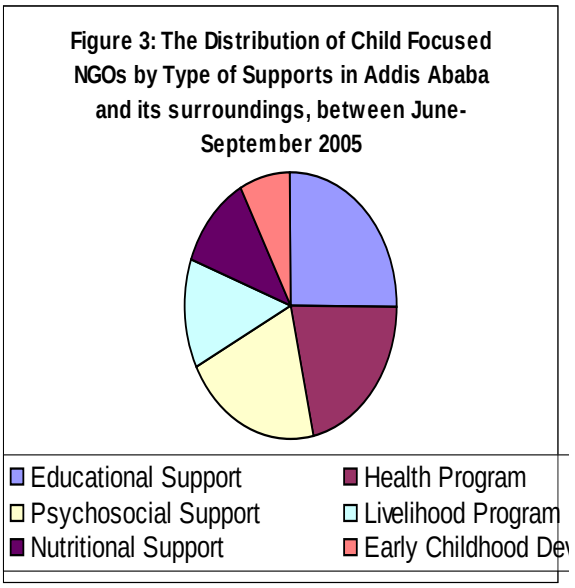
It is clear and interesting to see that there are significant differences in defining OVC among children-focused NGOs. Some organisations lack a clear definition for the concept orphan, but were involved in interventions targeting OVC. In addition, absence of clear guidelines and operational policies lead to the erroneous inclusion or exclusion of children from children focused organizations. Thus, the presence of a variety of operational definitions of OVC among children focused organisations reflects the lack of networking among the organisations as well as the absence of a national framework that defines standard operational guidelines to be followed by children focused organisations.

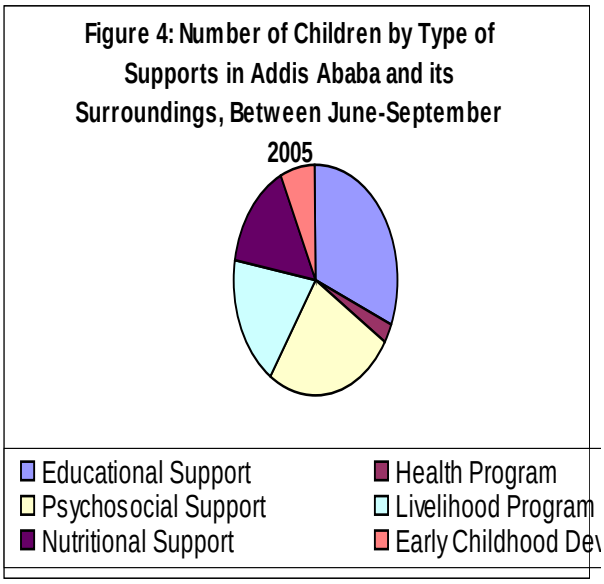
Further evidence of the study indicated that children-focused NGOs have provided support to OVC in six major areas:

- Educational support such as school uniforms, school fees, tutorial support, non formal education, school feeding programmes and school materials;
- Early childhood development including clothing, feeding, sanitation, nursery schooling and day care service;
- Psychosocial support such as counselling, home visits, recreational support, peer education, life skill training, succession planning and family reunification;

- Health support programmes which provide services such as medicine, HIV/AIDS prevention education, hygiene and sanitation, adolescence reproductive health information, vaccination, VCT and ART;
- Food support such as supplementary food, food rations (safety net) and financial support; and
- Livelihood support including income generating activities (provision of start up capital), vocational skill training (apprenticeship), agricultural and subsistence financial support (HACI 2006 15-19).

As far as the distribution of children-focused NGOs by the number of major focused areas stated above is concerned, the HACI (2006) study pointed out that out of the total of 129 children-focused NGOs contacted, 18% of children-focused NGOs have been involved at least two of the six intervention focused areas. 43.3% of organisations have focused on three and even four interventions. The remaining 38.3% of organisations have been engaged in all the focus areas (Ibid:14). As can be seen in Figure 3 and Figure 4 respectively, the distribution of organisations and children by type of support indicated that educational, psychosocial and health support have been the three major focus areas that received high attention by most children-focused NGOs. Accordingly, around 51 114 OVC in Addis Ababa and its surroundings have been assisted with educational support with the involvement of 115 children-focused NGOs. Around 96 children-focused NGOs have addressed the health needs of 42 888 OVC, while 95 children-focused NGOs have met the psychosocial needs of 40 643 OVC. However, children-focused NGOs have shown little interest to the remaining support elements such as livelihood, food and early childhood development. Only 60, 54 and 35 children-focused NGOs respectively have been engaged to meet livelihood, nutritional and early childhood developmental needs of OVC. A possible explanation is that the efforts made towards meeting the essential and basic needs such as food and clothing, promoting skills development, employment creation and establishing long term income generation alternatives have been limited to a few children-focused NGOs.





(Source: HACI 2006)

In general, despite children-focused NGOs efforts to promote the wellbeing of OVC through the provision of care and support services with community based response approaches, apparent limitations have been identified. Inadequate financing – often below standard – to meet the needs of OVC has been one major gap for the children-focused NGOs, amongst others. For example, despite an ad hoc OVC Task Force at the national level, it is estimated that a vulnerable child receives an average allocation of 25 US dollar per month, equivalent to ETB 2640 (300 US dollar) per child per year (FDRE 2004), most children-focused NGOs were able to cover only one third (ETB 837 or 95 US dollar) of the requirement to meet the major needs of OVC (HACI 2006). To put another way, the gap between the available resources and the requirements was ETB 1 803 (205 US dollar). Similarly, studies conducted in other regions of Ethiopia showed that most children-focused NGOs provide less than ETB 200 (10 US dollar) for each OVC as stipend, too small to fulfil the basic necessities of the children where the price of food items and other important goods is high, especially in urban areas of the region (ANRS-BOLSA 2008). Furthermore, the proportion of OVC who provide care and support in the form of food and clothing is not addressing the magnitude of the problem because food and clothing are found to be the most severe problems for many children who lost their parents or whose parents are bed ridden.

3.2.2. Rights and Legal Guidelines

This section surveys the existing international rights and legal guidelines together with the existing Ethiopian laws and policies regarding children in general and OVC at large.

3.2.2.1. Review of Existing International Declarations, Conventions and Covenants

The government of Ethiopia enacted most of the international declarations, conventions and covenants. The Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child give primary consideration for survival, development, protection, non-discrimination, participation and the best interest of all children, including OVC.

3.2.2.1.1. International Convention on the Rights of the Child

The international Convention on the Rights of the Child (CRC) advocates a **children's rights perspective.** It is because it recognises the responsibility of state parties and other duty bearers to intervene in promoting the rights and welfare of the child. All legal frameworks in Ethiopia are enacted based on CRC and human right issues and principles. CRC rests on the general principles of non-discrimination and gender equality (Article 3), best interests (Article 2), survival, development (Article 6) and participation (Article 12) rights of the child.

The convention recognises the rights of the child to health facilities and medical assistance, provision of adequate nutritious food, clean drinking water and living in a healthy environment (Article 24). It also recognises the rights of children to benefit from social security (Article 26). Children have the recognised right of education (Article 28 and 29). Accordingly, CRC emphasises primary education as compulsory, available for all and free (Article 28).

Moreover, the CRC give due emphasis to the protection of children from all forms of exploitation and abuse including protection from substance and drug abuse (Article 33), economic exploitation (Article 32), sexual exploitation (Article 34), child sale and trafficking (Article 35), emotional and physical abuse and punishment (Article 37). The state

has to work towards protecting children from performing any work that is likely to be hazardous or to interfere with their education, or to be harmful to their health, physical, mental, spiritual, moral and social development (Article 31).

3.2.2.2.2. The Africa Charter on the Rights and Welfare of the Child

The Africa Charter on the Rights and Welfare of the Child (ACRW) also recognises the holistic rights of children. The constitution of Ethiopia gives special protection and assistance to orphans and vulnerable children. The Africa Charter on the Rights and Welfare of the Child in Article 20 states the responsibilities of parents and other legal responsible duty bearers to ensure that the best interests of the child are paramount at all times; to ensure, within their abilities and financial capacities, conditions of living necessary for the child's development and to ensure that domestic discipline is administered with humanity and in a manner consistent with the inherent dignity of the child (MoLSA and UNICEF 2005).

According to the constitution of Ethiopia every child has the right to life, to know and to be cared for by his/her parents or legal guardians, to be protected from exploitative and abusive practices including corporal punishment and inhuman treatment in schools and other institutions and to promote equal rights of children born out of wedlock with children born in marriage (Art.36). Moreover, it considers the family as fundamental unit of the society which is institutionally entitled to protection by society and the state (Art.34) (FDRE 1995).

According to the Africa Charter on the Rights and Welfare of the Child, the state has the duty to provide assistance to caregivers and take the following measures based on its means and national conditions (Art.20):

- To assist parents and other persons responsible for the child and in case of need to provide material assistance and support programmes particularly with regard to nutrition, health, education, clothing and housing;

- To assist parents and other responsible parties of the child in the performance of childrearing and in ensuring the development of institutions responsible for providing care of children.

In general, international legal frameworks recognise all the rights and welfare provision guidelines of vulnerable children. However, realisation of these rights, including survival and development, depends upon the economic development of member nations. If there is not the necessary national capacity to preserve these rights of children, the state can call for resources from the international community. Regarding the responsibility of the state to allocate resources, CRC (Article 4) depicts that 'States parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international cooperation'. Similar to the convention, allocation of resources to promote the welfare of orphan and vulnerable groups is not mandatory in the context of the constitution of Ethiopia. It is stated as: 'The state shall, within available means, allocate resources to provide rehabilitation and assistance to the physically and mentally disabled, the aged, and to children who are left without parents or guardians' (FDRE 1995:17).

3.2.2.2. Review of Existing Ethiopian Laws and Policies Regarding Children

Ethiopia has adopted laws that protect children against the violation of their fundamental rights. The adopted laws guarantee access to information, education, health services, and other social services ensuring their rights of inheritance, and protect them against sexual abuse. These laws, in addition to the constitution of Federal Democratic Republic of Ethiopia (FDRE), are found in the Revised Family Code of Ethiopia, the Penal and Civil Code of Ethiopia, and other legal instruments.

For example, in the context of the Family Code of the FDRE, the father and mother are the core tutors and guardians of their children. Parents are also responsible to appoint through a will, the guardian or tutor of their minor after his/her death. In the absence of the appointment of a caregiver and when children lost their parents, the family code devolves the function of guardianship to relatives of the child in order of importance. The first

responsible guardians are ascendants of the child. In their absence, the brothers or sisters of the child who attained majority are the next responsible persons to nurture the child and in default of siblings, the uncle and aunt have legal accountability to care for the child (FDRE 2000). According to this code, the role of relatives for the foster of orphan and vulnerable children is very important.

In addition to adopted laws that protect children against the violation of their fundamental rights, the development of social welfare policy (1996), which has been formulated to feature development, prevention and rehabilitation of a social condition, provides priority concern for OVC. In this policy, child welfare is one of the areas of focus. The policy states that appropriate and comprehensive care and services shall be extended to children so as to ensure their holistic and harmonious development. The policy further states the conditions that will enable orphaned and abandoned children to get the assistance they need and to eventually be self sufficient, among other provisions (MoLSA 1996).

With regard to OVC, Ethiopia has also enacted the National HIV/AIDS Policy in August 1998 even though it was years after the first cases of AIDS were reported in Addis Ababa in 1986 (Laster et al 1998: 139). The adoption of a special policy on HIV/AIDS arouse out of the realisation that the HIV/AIDS poses a serious threat to the viability of the country. While the policy emanates from 'the need for a concerted multi-sectoral effort in controlling the spread of HIV and mitigating the impacts of AIDS', it also underscores the need for ensuring and protecting the wellbeing and rights of OVC (MoH 1998). Article 2.4 stresses the need for proper institutional care; home and community based health care and psychosocial support for PLWHA, orphans and surviving dependants. The policy also encourages efforts for provision of care and support for children orphaned when one or both parents die of AIDS. Ideally parents shall get proper counselling to ensure clear arrangements of suitable options to be made among extended family for community support for their children before death (Article 6.8). Equally important is that the policy prohibits discriminatory practices against OVC. Article 8.4 underlines the fact that '…orphans shall be treated in a manner similar to other members of the community with the same access to

educational programmes, serological testing, inpatient and outpatient care and shall not be subjected to discrimination practices on the basis of HIV/AIDS'.

Though the policy has made far reaching provisions for the protection of OVC, relevant laws and guidelines to enforce these provisions have not yet been enacted.

To sum up – policies and legal frameworks are too general which need specific provisions and implementation instruments. There are no specific legal frameworks concerning the care and support to be given for OVC who lack caregivers due to death and other reasons. For instance, immediate measures to be taken by the state when primary caregivers are not in a position to care and support their children, is lacking. It seems that assistance to most vulnerable children depends upon the economic capacity of the country, region, and immediate caregivers and their relatives.

3.3. Summary of the Main Themes

This chapter has been concerned about two main issues: the impact of HIV/AIDS on child household heads and the social support mechanisms in existence to promote the wellbeing of these households.

The impact of HIV/AIDS on child household heads has given us insight to understand the underlying causes and challenges of household care giving efforts in households headed by children affected by AIDS. HIV/AIDS has recast the pattern of orphaning in sub-Saharan Africa. The increasing numbers of double orphans as a result of the AIDS epidemic has become evident on the continent. It has also been found that the collapse of the traditional and modern mechanisms have left children with no choice but to establish a household with the eldest often taking the headship. Despite alternative care systems, children can also make a choice rationally and consciously to establish their own household, mainly for three different reasons: (1) they do not want to be separated from their siblings and go to an orphanage; (2) out of fear of being mistreated or exploited in foster families; and (3) when they have decided to stick together to fulfil promises to their late parents. Regardless of the

underlying causes, the diverse problems for households headed by orphan children are evident. Children in these households experience all forms of poverty (such as the lack of fulfilling basic needs and necessities and exclusion from essential social services), emotional and psychological challenges including trauma, depression and anxiety.

The children-focused NGOs have made considerable efforts to promote the wellbeing of orphan children by providing support such as education, psychosocial assistance, health care, food and nutrition and early childhood development care in their respective operational areas at community grassroots. Despite such considerable efforts however, there has been apparent limitations among children-focused NGOs: one is that insufficient budget allocation to meet the needs of OVC. Furthermore, the proportion of OVC who received care and support in the form of food and clothing is not comparable to the severity and magnitude of the problem. What is more, the absence of clear guidelines and operational policies lead to the erroneous inclusion or exclusion of children from OVC services.

All rights and legal frameworks in Ethiopia are enacted based on CRC and human rights principles. The Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child (ACRWC) describe the standards to which those responsible for the raising of children should aspire. According to the convention and the charter, children are entitled to special care and protection, and should grow up in a family environment, in an atmosphere of happiness, love and understanding. Actions affecting children should always take the best interest of the child first; there should be no discrimination between children; special protection to the most vulnerable or needy must be provided, as all children have the right to survival and development; and the child has the right to have views considered and to participate in decisions affecting them, according to age and maturity.

In sum, Ethiopia has plenty of laws and policies regarding children on paper. Ethiopia is the first to adopt and sign international laws, but the problem is the enforcement of laws and

policies. Adopted laws and formulated policies do not have strategies and guidelines for how they are implemented.

In the following chapter, I will discuss methodology of the research to this particular study.

Chapter Four: Methodology of the Research

This chapter sets out the research methodology that I have employed for this particular study. It specifically emphasises the study design, methods of data collection and analysis together with the problems of the research strategy and the ethical considerations.

4.1 Study Design

This study is a qualitative study by design whereby pertinent information in relation to the topic of the study have been gathered from primary sources using 'purposive sampling' procedures. The study is based upon fieldwork consisting of interviews with child household heads affected by AIDS, their siblings and key informants in Addis Ababa. In this study they will be referred to as 'participants'. The field study was conducted over a period of 5 weeks commencing from 15 March until 20 April 2009. Since the study had been conducted as exploratory research, the following data collection methods were employed: unstructured (face to face) interviews, focus group discussions and key informant interviews. During the interview a tape recorder has been used. Notes have also been taken of the responses of the participants during the interview. Soon after the interview I have transcribed responses of the participants into text.

4.2 Methods of Data Collection

Different data collection methods in this particular study have been used with different target groups.

4.2.1 Unstructured (face-to-face) interview

Primary data have been collected from 10 households – 5 households from girl child heads and the remaining 5 from boy child heads - headed by children using the life story research method. The life story mainly focused on these household heads as these children have been the main targets of the research. Using the interview guide (see Addendum A;I), I collected qualitative information in face to face interviews by going directly to the homes of child

household heads. During the process, I have become part of their world as much as possible. The interview lasted 46 minutes on average.

The life story research method has many advantages including getting 'other kinds of information that do not get into the public record' (Yow 1994:11). The method is also advantageous 'if a respondent does not understand research questions in a personal interview, the researcher can fill in, and if, the researcher senses the respondent is not answering fully, he/she can probe for more complete data'(Bernard 2006:256). Moreover, the physical presence of the interviewer helped establish the rapport needed for asking sensitive and personal questions about the painful experience of bereavement (Caserta et al 1985) and 'comprehending the complexities of a person's day-to-day decision making and the ultimate consequences that play out in that life so that insights into the broader, collective experience may be achieved' (Cole and Knowles 2001:11).

4.2.2 Focus Group Discussion

Focus group discussions have also been held among siblings of the 10 identified households separately in two rounds. In the first round 5 children (2 girls and 3 boys) and in the second round of the focus group discussion the remaining 5 children (3 girls and 2 boys) were drawn from the households headed by children. The aim of these discussions has been to see the nature of hierarchal relationships that existed in the household, the general relationships between brothers and sisters and conflicts of household management in order to attain a wider picture of their day to day life. The focus group discussions, which took 58 minutes on average, were held in my work place organization meeting hall (see Addendum A; II). But, since the participants have come from different places, I have paid the transportation fee for each participant. Additionally, efforts have been made to create a relaxed atmosphere (making comfortable seating arrangements and telling stories and jokes) for children who shared the event.

This method has been selected because of its advantage in acquiring deeper understanding and gathering detailed information from the target groups regarding the issue under

investigation. This is believed to help in getting detailed information about the household power dynamics and the inner feelings of these siblings because being in a group with others that have similar issues to discuss, may give confidence to speak about their experiences in a way which may not occur in one-to-one interviews (Young 2004: 34-58; Goode and Hatt 2006:313-41; Bernard 2006).

4.2.3. Semi-structured interview

Using the semi-structured interview method, the study gathered evidence from three key informants drawn from the local institutions and NGOs on the support mechanisms that existed for such households and the perception of key informants regarding the problems of child household heads affected by AIDS. In addition to the semi-structured interview being undertaken with the informants, available data relevant to the subject were gathered and analysed. Based on my prior knowledge, I have selected these organization for that fact that these organizations were not only among the organizations that worked in partnership with my current work place organization but also they were considered one of the robust organizations who provided holistic care and support services to OVC for many years. This helped me much to gather the relevant information without any trouble.

Semi-structured interviews are structured in a sense that a list of pertinent issues for investigation is drawn up prior to the interview (see Addendum A;III). Denzin and Lincoln (2000:649) state that such a list contains some precise questions and their alternatives or sub-questions which depend on the answer to the main question. According to them, semi-structured interviews help to clarify concepts and problems. It also works very well in projects where the researcher is dealing with 'high-level bureaucrats and elite' members of a community' – people who are accustomed to efficient use of their time (Bernard 2006:212).

4.2.4. Sampling Techniques

The study has employed a 'purposive sampling' method. The life story research that this particular research took up called for such a sampling method. The selection of these households – both the face-to-face interview and focus group discussion – has been purposive taking different attributes like age and gender into account. With this in mind the

samples in the research have been selected from both sexes within the age range of 12-18 that were enrolled in school (such as siblings in FGD) as well as those dropped out (child household heads) in order to provide for their household a means of survival. In terms of economic status the research mainly focused on those who were found in the lower income level.

I met the participants from the list I had obtained from my current work place organization and this helped me in accessing the participants and gathering the information without much difficulty. Prior to the interviews, meeting times has been set up according to the time schedules of the children who agreed to the interviews.

In depth research requires informed respondents, not just responsive respondents – that is, people whom a researcher chooses on purpose, not randomly. This is because the life story research often deals with sensitive personal cases. Bernard (2006:186) discusses this in detail: 'Come to think of it, just about everything is a sensitive topic when a researcher digs deeply enough. Sexual history is an obviously sensitive topic, but so the management of household finances when a researcher gets into how people really allocate their resources. People love to talk about their lives, but when a researcher gets into details of life history, he/she quickly touches a lot a nerves'.

4.3. Analysis Strategy

There is growing interest these days in the analysis of qualitative data (Bernard 2006:463). Qualitative data analysis is an iterative process (Strauss and Corbin 1990:68) by which a researcher may study transcripts of the data in order to understand the relevant aspects. A well tested method in analysis of qualitative data is what Bernard (2006:492) calls 'memoing' which entails keeping continual notes about the coding and new directions of the research. Inductive or 'open coding' allows understanding to emerge from studying the texts (Ibid:493). It means that highlighting some of the words or phrases a researcher thinks might be important may turn into themes. In fact, Strauss and Corbin (1990:68) recommended explicitly using actual phrases of the text – the words of real people – to name themes, a

technique they call **in vivio** coding. Milles and Huberman (1994:56) say simply: 'coding is analysis'.

In this research the data analysis strategy what Bernard (2006:495) calls 'an interpretive analysis' was employed. This included *transcription* and *text management*.

I have carefully transcribed the raw data of every interview after which codes were inserted directly into the transcribed texts of the field notes. The codes have been mnemonics of my own that were given according to the participants' name and place – to conceal identities – and to each topic of the research as a measurement device to relate or mark differences of the participants' answers under each topic. Following the transcription, the pile sorting method has been used to organize themes of the transcribed texts in accordance with the points of discussion from the interview guides.

Finally, analysis has been made in choosing segments of the text – verbatim quotes from participants – as exemplars of concepts or exemplars of exception to the review of the literature. Replies (real words/phrases) from participants are presented in this report in Amharic language. However, to give access to a wider readership, it has been translated into English and both languages are presented side by side in this report.

4.4. Problems with the Proposed Research Strategy

'Nothing in research is more important than validity' (Bernard 2006: 53). Focus group discussion research method may lead the group to follow the dominant ideas in the group and follow the ideas of a child that is most influential in the group (Ibid: 233), hence the method is a threat to both internal and external validity. But, I have made efforts to overcome this problem by giving equal chance to the respondents which, I have observed during the interview, made them free to participate in the discussion.

The life story research method may also be influenced by the 'history and context in which they occur and are told' (Kakuru and Paradza 2007:11) and making generalizations may be difficult since the information gathered mainly lies in the selectivity if narrators (Yow

1994:17). In addition, if the stories are not collected with great care it may result in a picture that is ‘narrow, idiosyncratic or ethnocentric’ (Ibid:16).

Another typical problem of the life story research method is ‘ethics in probing’. This is because in probing one can get intimate information by making people ‘open up’, hence a more responsible a researcher will ensure that people do not suffer unnecessary emotional distress in doing so. According to Bernard (2006:233), ‘informants who divulge too quickly what they believe to be secret information can later come to have real regrets and even loss of self-esteem. They may suffer anxiety over how much they can trust you [a researcher] to protect them in the community’. According to him, the responsibility to protect people from becoming emotionally burdened for sharing their secrets is an ethical challenge for all researchers. However, I have made efforts to curb such emotional reactions from respondents, by providing them assurance of trust to the extent of ending an interview when I sensed that respondents were uncomfortable with having spoken too quickly about a sensitive topic. After a while, however, I have engaged in light conversation again with no probing.

4.5. Ethical Considerations

Ethics is a critical reflection on morality. Armson and Carlsmith (in Cohen and Mannion 2000) argue that conducting research involves tension from two sources. The tension that exists between two sets of related values held by society: a belief in the value of free scientific inquiry in pursuit of truth and knowledge; and a belief in the dignity of individuals and their right to those considerations that follow from it. Striking a balance between the two requires skill and involves ethical considerations particularly from the point of view of the research participants.

In certain cases, participation of children in research becomes indispensable because information obtained from other individuals cannot answer the question posed in relation to children. To this end, I have considered four important ethical guidelines when gathering data from primary sources:

- Children as research subjects present special problems. Some even say that it is best to avoid using children unless one can not. Studying children requires a researcher to obtain informed consent from the legal guardian or parent. The case of children in this particular research was challenging since neither a legal guardian nor a parent was present to grant me written permission because these children, during the field study, have lived with no adults or extended families. The only option that I had was to obtain written permission (see Addendum B) from community workers who regularly worked with these children as guardians/caregivers and provided children with care and support services. The permission process has been finalized prior to the interview.

- Once permission was granted, seeking consent from the participants has been followed. But, before seeking consent from the participants (child headed households and their siblings), I have informed them of all the aspects of the research that might have affected their willingness to participate and answer the participants' questions. Moreover, I have respected the participants' freedom to choose to participate in the research or not by giving the participants the opportunity to give or not to give consent to participation as well as to choose to discontinue participation at any time. Wherever appropriate, I have provided the participants information about the planned research including the purpose of the research;[8] the likely benefits of the research; the procedures to be undertaken and duration; and that participation in this research has been voluntary and that the participant might have withdrawn from the research at any time;

- Participants of this particular research have been told that they have been granted no special incentives for partaking in the research; and

[8] The consent of respondents has been recorded when taping the interview.

- I have treated all the information obtained from the research participants as confidential. The participants' identity has been concealed in written and verbal reports of the results.

Before I conclude, it is important to reflect some of the experiences I have had during my field study. All the child household heads in my study lived in abject poverty. They spent much of their time looking for casual work to provide adequate food for the household and managing the meagre food supplies. If they were fortunate, the child household heads survived on up to ETB150 (15 US Dollar) per month, however, often times they had much less than that. Asking helping hands might not be surprising for these children since they have been living in such traumatic conditions. *"I have carefully listened what you told me. I understood you have come for your benefit (doing my research) without giving me a penny"*, said one boy following my research introduction, specifically after he had been told that he had been granted no special incentives for partaking in the research. I felt split in two for I wanted to give him some money however, the research ethics, which I am bound by, did not allow me to do so. I left the boy, but with his stories – for my benefit as he said – without giving him a penny. On the way home, I told myself the research ethics, which I have been bounded by, made me a miser. A few days later however, I came to the conclusion that a researcher should never be driven by situations and has to maintain his/her emotional reactions. I can only hope that this study will eventually benefit children in similar situations even though this particular boy may not benefit from it.

To sum up- in this chapter I have briefly discussed the importance as well as apparent limitations of the research strategy/methodology I have employed for this study. I have also stated the ethical guidelines which were followed in this particular study.

In the following chapter, I will analyse the data gathered from the field study.

Chapter Five: Data Presentation and Analysis

This chapter addresses the two main research topics: *the roles and challenges of household care giving efforts in child household heads affected by HIV/AIDS and the social support mechanisms that are available to assist these households to cope with the challenges they have faced.*

As an exploratory research the study gathers evidence on how child household heads affected by AIDS adapted to their new circumstances, what events meant to them, how they viewed what had happened to them and around them. All of the child household heads in this study were double orphans with age ranges from 12 to 18 and had no relative to take on the responsibility of caring for them. At the time of the study, the participating child household heads of the study looked, on average, after three siblings with age ranges from 4 to 15. With regard to the gender composition, the study gathered evidence from five households headed by boys and the remaining five households by girls.

This chapter centres on three main issues: the roles and challenges of child household heads in household care giving efforts; the perception of siblings in child household heads; and the role of children-focused NGOs to promote the wellbeing of children in these households.

5.1. Child Household Heads: Household Care Giving Roles and its Challenges

In chapter three the available literature on the roles and challenges of child household heads affected by HIV/AIDS provided insight in understanding the situation of households headed by orphan children. In this chapter the fieldwork of the study will further such insight by providing information from primary sources.

Children have often assumed parental responsibilities during the illness of their parents and continued this role after the death of their parents in many countries in sub-Saharan Africa. There has also been an indication that children could make a choice to establish their own

households: they may not want to be separated from their siblings and go to an orphanage; for fear of mistreatment and abuse by relatives; and when they have decided to stick together to fulfil promises to their deceased parents.

Taking on the responsibilities of a parent, child-household heads generally do the same as adults do in the household: work to support siblings, get food, clothing and shelter, and deal with the emotional wellbeing of their siblings, amongst others.

Apart from their roles, child household heads have faced countless problems. Exclusion from basic essential social services such as education and economic security to meet the demands of their households have been the biggest challenges for orphan children heading a household. In addition, other psychological (emotional) challenges result from witnessing a parent's illness, dealing with death, the absence of guidance and mentoring, and the unmet need for love and security.

This section specifically analyses aspects pertaining to the reflections of the child household heads in the study on the roles they have such as assuming parental responsibility, their perception of taking on these responsibilities and the leadership strategy they have used in managing the household. It also analyzes stories of the child household heads on the challenges they have faced, the coping strategies they have used to ease their grief and pain, and their views on the future. Though the research gathered evidence from 10 selected child household heads, I often found similar responses relating to specific themes.

5.1.1. Being a Head of Household: Assuming Parental Responsibility

The responsibilities for many child household heads in the study began with caring for a parent who was ill, and continued after the death of their parents.

#□ ‘; Ÿ□ $‹ Ÿ1997 ¯.U. ËUa ¾u?}cw □Lò J"Ÿ<:: □‘, u1998 ¯.U. V}‹:: ›v,U w²<U dÃqÃ u²=Á¨< ¯Sƒ uÖ“V V}:: ¾SËS]Á MÏ eKJ"Ÿ< Ÿ²=Á” Ñ>²? ËUa

“I started taking the responsibility of the household in 2005-when my mother became sick. She became seriously sick and passed away. In the same year my father became

¾u?}cw □Lò J"Ÿ<:: HLò'~" Á¨cÉŸ<uƒ Ui"Áƒ u}cv‹" □"Ç¾u}"" u"ƒ" vv□‹" uƒ □"ÇÉÓ eM '¬::$

sick and died. That was when I started doing some casual work for a living for myself and my four siblings. Because I am the eldest, I have taken this responsibility to keep my siblings together in our parents' home."

#›v, uÖ" □V u1996 V}:: Ÿ²=ÁU Ÿ□"□‹" Ò` □"•` 'u`:: w²<U dƒqÃ □"□‹'U uÖ" Ÿ□SS‹ u%EL u1997 ¯.U. V}‹:: u¨p~ u×U Ó^ Ñw„~ 'u`:: U" TÉ"[ÇKw˜U ›L¨<pU:: Ui"Á~U G<K~U ¨LĐ‰‹" ØK¨<" N?Æ:: □'@" G<Kƒ □"¡ ¨"'ÉT@" □l, w‰ k[":: ¾SËS]Á MÏ□"ÅSJ'@ Ÿ²=Á" Ñ>²? ËUa ÁÑ–G<ƒ" Y^ G<K< SY^ƒ ËS`Ÿ<::$

"My father was sick for a long time and passed away in 2004. We continued staying with my mother until she died in 2005. I did not know what to do because both our parents who used to look after us died. Only the three of us remained. I am the eldest. When I saw the situation, I started doing some casual work to earn our living and days were passing like that."

¾U"•[¨< Ÿ□ "□ ‹" Ò` w‰ 'u`:: □ dDU u1999 ¯.U. ØL" V}‹□T u'u[‹uƒ Ñ>²? ¾‰MŸ<ƒ"" ÁÑ–G<}" Y^ G<K< uSY^ƒ Ku?}cv‹" Ñu= ›S× 'u`:: ŸV}‹ u%ELU ÃI"" Y^Â" kÖMŸ<uƒ:: Ui"Á~U□'@ ¾SËS]Á MÏ '˜:: ŸY_ ›"É ¨"ÉU" □›"ÉÉ ›K<˜: : ¾U‹K¨<" Y^ G<K< □W^KG<::$

"We only used to live with my mother until she became sick and died in 2006. I used to work hard in causal work in order to look after my mother. Later she died, as I am the eldest, I had also become responsible for my two younger siblings – my brother and sister. I always try my best to do some causal work".

G<K~U ¨LĐŠ u1999 ¯.U. SÚ[h LÃ V~:: Ÿ²=Á" Ñ>²? ËUa '¨< ¾u?}□ẁ ¾J"Ÿ<ƒ:: Ui"Á~U T"U ²SÉ□ –" K=Áe}Ò ›MðKÑU::$

"I became head of household in 2007. My father died in late 2006 and so did my mother in the same year. I started being head of household while my mother was sick and continued still, because no relatives wanted to take care of us."

#›G<" 16 ¯S,'¨<:: ¾u?}cw □Lò ¾J"Ÿ<ƒ Ÿ1999 ¯.U. SÚ[h ËUa '¨<□:", □" ›v, u²=Á" ¯Sƒ uÖ" □S¨< V~:: ÁÑ–G<ƒ" Y^ uSY^ƒ K□'@" K□"""¡ ¨"'ÉVŠ" □l„Š ¾T>J" Ñu= ›S×KG<::$

"I am 16 years old. I became a head of household in early 2007. My father died in 2006 while my mother died in 2007. It was in that same year when I began to take care of my younger three siblings and myself through doing piecework."

›G<" 18 ¯S, '¨<□:", u1995 ›v, ÅÓV u1997 uÖ"□ S< V~:: ›v, □"ÅV} ¨Å ²SÊ‰‹" }ÖÓ}" 'u`:: 'Ñ` Ó" ²SÊ‰‹" ¨LĐ‰‹" Ø\ c-‹ □"ÇM'u \ u}ÅÒÒT> Ã'Ó\"" ÁÑK<" 'u`:: Ÿ²=Á u%EL }SMc"

"I am 18 years old. My mother died in 2002 and my father died in 2004. After losing both our parents, we were taken to our relatives who rejected us saying, 'your parents were not good'. We began to live along together.

Kw‰‹" S•` ËS`"□:'@U ¾u?}cu<" □Lò'ƒ ¨cÉŸ<::$	*That is why I began to do piecework."*
□", u1998 ¯.U. V}‹:: ›v, ÅÓV u2000 ¯.U. V}:: ›v, ŸSV~ uòƒ K?L T>eƒ ›Ów„ 'u`:: ¾□"Ë^ □"□‹" ÅÓV □—" ›ƒðMÓU 'u`:: u²=lU ¾}'d ÁÑ–G<ƒ" Y^ uSY^ƒ K□'@" KZeƒ □'ì ¨"'ÉVŠ" □l„Š ¾T>J" ÑU= ›Ñ— KG<::$	*"My mother died in 2005 while my father died in 2007. When my mother died, my father remarried another woman. I began to take care of my three young siblings and myself because our stepmother did not want us.*

Some of the participants repeatedly referred to the bad treatment relatives made on those who are not their biological children:

#u›G<'< Ñ>²? ÁK ²SÉ Ñ"²w ŸK?Kl ›ÃðMÓlU:: □'c< K^d†¨< MÐ‹ K=Ú'l Ã‹LK<:: K^d†¨< MÐ‹ Mwe c=Ñ²< □"'"D" ›"}" µ` wK¨< ›Á¿lU::$	*"Relatives nowadays will not look after you unless you have money. They would prefer to look after their own children. They may buy clothes for their children but they would not bother about you."*
#²SÊ‹ Ò` N?Ål S•` ƒ‹LKl:: 'Ñ` Ó" ƒÑKLKl:: □"ì ¨"'ÉT@ u›"É ¨pƒ ¾J' ²SÉ Ò` }ÖÓ„ 'u`&□'c< KMÐ‰†¨< ¾J' 'Ñ` c=Ñ²< ¨"ÉT@ ƒ´ ›ÃL†¨<U 'u`:: UÓw G<L uÅ"w ›ÃcÖ<ƒU 'u`::$	*"You can go and stay with relatives but they differentiate. Let me tell you the experience of my younger sibling who has once been taken by our relatives. He told me that they bought things and eat without giving my brother even though he has seen them."*
#ÃN?" M'Ó`ŀLKG<:: ²SÊ‰‹" ›eÖÑ<"" ›ÑKK<"":: Ã¤¨< '¨<::$	*"I will say this: when we were taken to our relatives they rejected us."*

The reflections of some the participants stated above could clearly tell the reason why the child household heads in the study have assumed parental responsibility at their ages. They have assumed this role mainly for two reasons:

Firstly, because they were the *eldest child* in the household, most children in the study were assuming parental responsibility and becoming a head of household during the illness of their parents and continued after the death of their parents. As household incomes dwindled with the parents' illness and death, all of the household heads in this study stopped attending

school, for they have been committed to care for siblings in the household. They spent much of their time looking for casual work to provide adequate food for the household and managing the meagre food supplies. It seems that being the eldest sibling in the family is a motivational factor for the children in the study to take the headship responsibility.

Second, in most cases the child household heads in the study had an *acute sense of abandonment* by the extended family. In accordance with findings in other studies (Ansell and Lorraine 2004; UNICEF 2006) the children in this study repeatedly mentioned experiences of neglect, abuse and mistreatment by relatives and memories of such experiences have remained painfully in their minds. This theme was also frequently expressed in their views on the future in which they accepted the headship responsibility (or being a head of household) as their role for life- they had no expectations of either rejoining the extended family or being taken in by another family. This reflects the reality of the collapse of the extended family that has become another triggering factor for the existence of the child household heads in the study.

In the following section I will analyse the perception of child household heads in the study towards this role.

5.1.2. Being a Head of Household: Perception

Most child household heads managed to find some joy and satisfaction in being a head of household despite the hardship. Replies of some of the participants that may provide evidence for this are as follows:

#U”U □’”D” ƒUl`,” KSŸ□}M vM‹MU& □“‘“¡ □l„Š”‘“ ¨”ÉVŠ” uTe}ÇÅ` wl c¨< KSJ” ‹ÁKG<:: U”U ¯Ã’ƒ SØö c<e ¾Kw˜U:: SÓvƒU ›MðMÓU& U¡”Á~U K□“‘“¡ ¨”ÉVŠ“ □l„Š Ø\ UdK? SJ”□ðMÒKG<:: K?KA‹” uS`Çƒ w²< }U_›KG<::$	*“Despite the fact that I have discontinued my education, I have become a better person because I now take care of my four siblings. I should not get involved in any bad habits because I will then not set a good example for my siblings that I am looking after. I have learnt a lot about taking care of others.”*

#¾U"•[¨< u×U }†Ó[" '¨<:: 'Ñ` Ó" Á‹'< ÁÑ–Gƒ" ›wnp}I eƒ•` u×U Åe ÃMHM::$	*"We lived in extreme poverty- with a meagre income. However, it gives you pleasure when you use the resources well even if it is insufficient."*
#ÁK¨< ‹Ó` u=ÁeŸóIU ›"Ç"È ¾u?}cw □Lò SJ"I u×U Åe ÃMHM:: u}KÃ ÅÓV ›"Ç"É ÑA[u?„Š ÑAi ¾'@ MÏ ū¨ ›ÃµI G<K<U ÁMóM □ÁK< c=Áu[□~˜ u×U '¨< Åe ¾T>K˜::$	*"Though the living conditions we are living in make me sad, I sometimes become happy being head of a household. Especially, when people around – especially the neighbours- encourage me saying 'good boy, please keep on your responsibility, every thing will pass, be strong ---', and I become very happy."*
›G<" ¾u?}cw □Lò SJ'@ u×U '¨< ¾ÖkS˜:: ƒ□Óeƒ ›e}Ua—M:: □^c?"" u?}cu?" Te}ÇÅ` †ÁKG<:: ŸG<K<U 'Ñ` uLÃ ÁeÅe□M::$	*"My parental responsibility helps me a lot. For example, I have learnt patience. I have been able to manage myself and my siblings. That is the best of all."*

However, a few participants, especially the girls, were not happy being a head of household:

U"U ›ÁeÅeƒU:: Qí"„‡" KTe}ÇÅ` ÁK¨< ‹Ó` w²< '¨<:: ›"Ç"É Ñ>²? ^ei" □'m ÃK—M::$	*"Nothing. I have so many problems taking care of the children that I sometimes think of killing myself."*
#U"U ›ÁeÅe}˜U:: u}KÃ ÅÓV ›"Ç"É c-‹ □TT □ÁK< c=Ö\˜ u×U '¨< ¾U"ÅÅ¨<::$	*"I am not happy either, when I hear some people calling "mother", I feel very bad."*

The replies of the participants stated above have given us insight to understand the way the children in the study have perceived of being a parent.

In contrast to the literature study conducted, many of the child household heads in this study found that becoming a head of household/caregiver created happiness and a sense of pleasure. They have realized the positive aspects of being a head of household that made them happy, such as having learnt a great deal about running a home; being praised by

people, especially neighbours, about the way they look after their siblings; having become a better person, and looking after their siblings despite the hardships. Surprisingly the child household heads find some joy in their circumstances although there are exceptions.

Two of the girl child household heads experienced being a parent at such a young age as irritating and shameful. The one recalls the bad experiences she has had of being called a 'mother' by some people in her surrounding community though she was too young to be called that. The other girl despised the headship responsibility and only took it on to prevent her siblings from breaking up. The expressed sentiment of wanting to be dead by one of the research participants in this study was also found in other studies although only amongst a small minority (Benjamin et al 2005: 555-564).

5.1.3. Being a Head of Household: Leadership Strategy for Survival

Issues centred on the leadership roles specifically focused on understanding the child household heads in the study in relation to the division of roles and maintaining discipline in the household.

In relation to division of roles in the household, in the girl-headed households, the girls either took on most of the housework or delegated work to their siblings according to age.

#□'@ ∪?□‹'"' dçÇ& □"i □I, ÅÓV ¾u?ƒ □n-‹" □ØvK‹:: □"i ¨"'ÉT‹" Qí" uSJ'< U"U ›"c^¨<U::$	*"I sweep the house, and then my younger sister washes the dishes. The other one is a little boy, he does not do anything."*
#G<M Ñ>²? ŸS˜□Â ¾U'd¨< ∪Öªƒ '¨<:: Y^ ŸSN?È uòƒ ›eðLÑ> ¾J'<ƒ" ¾u?ƒ Y^-‹ c`Š& Ú`g? '¨< ¾U¨×¨<:: ÃI" ¾TÅ`Ñ¨< □"i ¨"'ÉVŠ" □I„Š ∪u?ƒ ¨<eØ Y^ U¡"Áƒ ūƒ‖Ük □"ÇÃc"ñ eKUðMÓ '¨<::$	*"I usually get up early in the morning and do all the housework by myself before I go to work. I do this because I do not want my siblings to get tired from doing household chores so that they can focus on their education."*

In the boy-headed households, many of the boys delegated housework to siblings and go out to earn money.

#¾UW^¨< ¾k" Y^ '¨<:: G<M Ñ>²? ŸÖª~ 12 c¯ƒ Ÿu?¨×KG<:: ¾υ?ƒ ¨<eØ Y^" u}SKŸ} ¨"É‚ŠŠ" uSŸóðM ÃW^K<::$	*"I leave for work at 6 o'clock so I do not help with the chores. But the children have divided duties among themselves. They each know what they are supposed to do everyday."*

But, one boy did some of the housework himself. He explained that:

#¾u?ƒ ¨<eØ Y^-‹" uÒ^ }ŸóõK" □"W^K":: ÃI" TÉ[Ñ@ υυ?ƒ ¨<eØ ßpßp □ 'ÇÃðÖ` ›É`ÕM:: K□ '@ ŸvÉ Y^ '¨< ¾}cÖ˜ ¨²}. . . }wKA ßpßp ›Ã'dU:□Lp uSJ'@ ª" ª" ¾T>vK< Y^-‹" □W^KG<:: ¾}k\ƒ" Y^-‹ □"Å¾□ÉT@Á†¨< ›ŸóõLKG<::$	*"The way I divide the work at home is that I make sure that all the work I have given them to do is done well and nobody is complaining. "No, you have given me difficult work", and so on. I make sure we work together. I also give myself something to do---- because as the oldest, I am supposed to lead by example, I should not give all the work to the young ones just because I am the one who fends for the home."*

With regard to discipline in the household, overall, participants said they had no serious problems with disciplining younger siblings. But, a few talked about their problems with younger siblings:

#›"Ç"É Ñ>²?□'c<" Sq×Ö` ŸvÉ '¨<:: KSUŸ`" KTe}T` wƒV¡`U }ÅÒÒT> el}ƒ c=ðêS< □Ñ —†ªKl:: 'Ñ` Ó" T"U □"ÅK?K"'w‰‹"" □"ÅU"•`" ¾'@" U¡` SeTƒ □"ÇKv†¨< e'Ó^†¨< υSççƒ ÇÓS— el}ƒ □"ÅTÃðêS< nM ÃÑu<M—M:: Á" Ñ>²?'@U υ×U □Åc□KG<::$	*"Sometimes it is difficult to control my younger siblings; you try to teach them or advise them, but they continue doing the same things. By then, I sit him/her down and say, "Listen, we have been left alone in the world, just as we are. You should listen when I am teaching you. There is no one who can teach you better than I can."*
#›"Ç"È ¾U'Ó^†¨<"" ¾US¡^†¨<" 'Ñ` uõèU ›ÃcS<U:: ÃN?'@ ÑA[u?„‰‹""	*"Sometimes my siblings do not listen to what I tell them, especially concerning*

□Ö^“ eKc\ƒ YQ}ƒ“ Øóƒ□“Ñ^KG<:: ÑA[u?„ŠU ÃS¡b†ªM:: ¾ÑA[u?„Š U¡` u×U ÖnT> ’¨<:: U¡”Á~U ¨”ÉV$□¶„Š ÇÓS— el}ƒ c=ðêS< ›L¾G<U::$	*duties. I call my neighbours to come and help me when I fail to manage them. They talk to them. It does work because my siblings do change after being talked to.”*

The reflections stated above indicate the strategies the child household heads in the study have used to maintain their household management.

In fact most child household heads had no serious problems with disciplining siblings. However, those who have faced this problem have used different strategies including advice and the involvement of neighbours, which they believed to be pertinent to resolve it. Advice centred on being respectful and looking after the younger siblings. It seems that those siblings who were advised with guiding words from the child household heads, value their instructions and try to live up to the words of their child household heads. For child household heads who failed to manage the discipline of their siblings, neighbours have played an important role to instruct and advise the siblings.

Housework has been dealt with in different ways by the child household heads in the study. Many of the boy household heads have never been involved in doing housework and they have delegated the housework to their siblings. In the girls headed households, responsibilities have been shared in doing the housework. The girls either took all the housework upon themselves or shared it with their siblings. It seems that housekeeping roles in these households reflect the gendered nature of responsibilities in the Ethiopian culture.

5.1.4. Being a Head of Household: Household Care Giving Challenges

All the participants in the study reported that they had experienced a set of socioeconomic and psychological (emotional) challenges. All of the children talked about the decline in their standard of living since their parents were deceased. They lacked food, clothes and money for school fees and uniforms for their siblings. All the participants who used to go to school can no longer do so. All did ‘casual work’ in order to survive. For example, some of the girls went to sell items such as cigarettes, toilet paper and chewing gum at bus stations

and at crowds during the day and at bars and hotels at night. Other girls went to the more affluent residential areas in search of work such as washing clothes and as housemaids. Such work is hard to come by.

#¨LÐ‰‹" □"ÅV~ QÃ¨ƒ ð}" J'w":: ›"Ç"É Ñ>²? uk" ›"È□"uLK":: Mwf‰‹" c=ÁMlw" ¾T>Ñ³M" ¾KU:: u²=l G<'@□ ƒUl`," ›s`Þ ¾}KÁ¿ Y^-‹" □¾ðKÓG< SY^ƒ ËS`Ÿ<:: ›"Ç"È ¾}KÁ¿ ldlf‹" (c=Ò^' Te+"' fõƒ. . .) u}KÁ¿ x□-‹ □¾µ`Ÿ< □g×KG<:: ¾TÑ–¨< Ñu= u×U Ømƒ '¨<:: u=u³ u¨` 100 w` u=Å`e '¨<:: u²=‹ Ñu= u?}cw" Te}ÇÅÏÓ ŸvÉ '¨<::$	*"Since our parents died life has become tough. Sometimes we just eat once in a day, and we do not have clothes. Unlike when my parents were alive, I now have to look for piecework to raise money for looking after my siblings. I sometimes sell items such as cigarettes, soft paper and chewing gum at bus stations. I sometimes wash clothes for other people in the surrounding area. I get paid up to 100 birr[9] per month and it is not enough to buy food for my four siblings and myself."*
#□"□‹" □"ÅV}‹ ƒUl`," ›s`Þ K□""'i ¨"ÉVŠ" □l„Š ¾ƒUl`ƒ ¨Ü-‰†¨<" KSgð" ¾}KÁ¿ Y^-‹"□c^KG<:: ›G<" u}SLLi'ƒ ¾u?ƒ W^}— '˜:: ¾TÑ–¨< Ñu= u×U ƒ"i uSJ'< Ku?‹" ¾T>ÁeðMÑ<ƒ" ¨Ü-‹ KSgð" Ã†Ó^M::$	*"Since our mother died, I have left school to look for jobs because I have no money to pay the fees of my siblings and feeding them is also a big problem. I work now as housemaid. I do all the housework, but the pay is too little."*

Similarly, the boy household heads have reported that they have been doing different types of casual work for the survival of their households.

#□"□‹" ŸV}‹ ËUa KŸõ}— ‹Ó`" YnÃ }ÒKØ":: □'@ uÓK? ¾}KÁ¿ Y^-‹" wW^U ŸUW^¨< Y^ ¾TÑ–¨< Ñu= u×U ƒ"i uSJ'< ¾□"'"l ¨"'ÉVŠ"'" □l „Š" KUÓw KMwd†¨<" KƒUl`ƒ u?ƒ ¾T>ÁeðMÒ†¨<" ¨Ü Sgð" ›M‰MŸ<U:: ›G<" u›"É J,M ¨<eØ uØun W^}˜'ƒ }kØ_ □¾W^G< uTÑ —ƒ 150.00 ¾¨` Ñu= □¾•`" '¨<::$	*"We suffer so much since my mother died. I do not manage to provide sufficient food and clothing for my siblings as well as to pay their school fees. Now, I work as a guard for 'X' hotel. I get 150 birr[10] per month, too little to cover the needs of my three younger siblings."*

[9] This is equivalent to 10 US dollar.
[10] That is equivalent to 15 US dollar.

uSËS]Á õ¾M□¾Ñ³G< uƒ`õ SgØ ËS`Ÿ<:: 'Ñ` Ó" Ÿe_ }¨<Ÿ<ƒ& uSkÖMU i"Ÿ<`ƒ' +T+U" É"⊠gØ 'u`:: □c<U ›¡ea˜ }¨<Ÿ<ƒ:: ›G<" ›"É É`Ïƒ uT>cÖ" ¾UÓw ldle □¾•`" '¨<::$	*"At first, I used to buy goat meat and re-sell it then I went broke. I started selling onion, tomato and potato, but I ran out of money again. Now I just wait for the food support (such as wheat flour and food oil) that has been provided for our household by "X" organization on a monthly basis."*

As far as other issues such as health is concerned, all the child household heads in the study worried more about the health needs of their siblings than their own. Under the circumstances, it is not surprising that health issues are more worrying to them, considering that most parents died because they were ill. In addition to their worries, the medical facilities are difficult to access if there is no money in the household.

Testimonials of the following three participants emphasize the problems child household heads in the study face when illness strikes either of them or their siblings:

#›"Ç"É Ñ>²? Ñ"²w dÃ•`l Qí" MÏ K=□SUwl Ã‹LM:: Á" Ñ>²? u×U ÁcpnM::$	*"Sometimes a child is sick but you have no medicine to give him/her. This is sad."*
#¨"ÉV‹l" □l„‹l u□SS< Ñ>²? T"U ¾T>[Çl M□× ƒ‹LKl:: ÃN? u×U ¾T>ÁeÚ"p Ñ<ÇÃ '¨<::$	*"When your siblings get sick and you do not have anyone to help you, it brings sadness."*
#¨"ÉV‹l" □l„‹l c=□SS< Åe□ ¾T>vM 'Ñ` □×Kl:: Ñ"²w □"ÅK?Kl e□¨<p ÅÓV Ûl' Ûl' □uÉ' □uÉ Ác˜GM::$	*"There is no happiness when your siblings are sick. This sometimes makes me cry, crying deeply. This sometimes makes me feel mad."*

With regard to external help, participants said that they had been supported in the form of food, clothing and educational materials by service providing institutions such as NGOs. However, most participants indicated that the support they had received from such organizations were insufficient in addressing the severity and magnitude of the problems they have encountered in their households.

Also, some participants reported that they had received vocational and skills training with the financial support of NGOs. Notwithstanding such efforts by NGOs none of the participants who had received skills training could find employment opportunities.

#›"É É`Ïƒ ¾Ñ"²w ÉÒõ ›É`ÑAM˜ ¾ìÑ<` Y^ K feƒ ¨` cMØ—KG<:: Y^ Ó" ¾KU::$	*"With the financial support of "X" organization, I have received the training on 'Hair Dressing' for three months. However, I could not find a job since then."*
#u›"É É`Ïƒ ›T"˜'ƒ ¾}cÖ˜" ¾Zeƒ ¨` ¾Mwe eôƒ YMÖ" □''ÅÚ[eŸ< Y^ KTÓ–ƒ u}ÅÒÒT> Vi_›KG<:: ›M}d"U::$	*"Soon after the completion of the three months training on "Tailoring" offered by "Z" organization, I was intensively looking for jobs, but it was in vain."*
#HÁ MÐ‹ J'" uÓ\ý uSÅ^Ëƒ ›"É É`Ïƒ ¾Zeƒ ¨` YMÖ" ū''Úƒ Y^-‹ cÖ'':: É`Ï~ ÃN?"" YMÖ" c=cÖ" uÒ^ J'" uÑu= TeÑ— Y^ ¨<eØ }WT`}" ^d‹"" □''É"K¨<Ø 'u`:: YMÖ"'¨<''U □''ÅÚ[e'' ›Ueƒ g=l w` S'h "ú□M }cÖ''" Y^¨<'' ËS`":: 'Ñ` Ó" w²<U d"kØM□}}ü:: Ui"Á~U ›"Å— ¾Ø_ °n SÓ¹ ªÒ¨<" ¾ª" □n¨<'' SgÝ õèU ›Á¨×U:: G<K}— u›"Ç"É ¾u<É'< ›vLƒ ÓÈKi'ƒ"□Lò'ƒ'' Sgi Ã□Ã 'u`::$	*"We have been offered a group based training on "Wood Work" for three months by "Y" organization. The group comprised of 20 members-I and 19 other orphans and school drop outs drawn from different parts of the city. The organization offered the training with the aim to engage us (the group) in income generating business activities. After completion of the training, this organization has also offered us 5,000 birr[11] as a start up capital. However, we did not manage the business properly so that we have been scattered. You see, because on the one hand the raw materials were expensive so that we could not make profit out of our products and on the other hand there was no work discipline among some group members."*

Beyond the socioeconomic challenges, the child household heads in the study have faced psychological (emotional) challenges:

#□", K[ÏU Ñ>²? u›MÒ LÃ eƒcnÃ T¾ƒ	*"For me, I just felt anguished because my*

[11] That is equivalent to 500 US dollar.

K□'@ enÃ 'u`::$	*mother's illness was going forward."*
#□", □T u'u[‹uƒ Ñ>²? K[ÏU Ñ>²? w‰Â" □u?ƒ ¨<eØ lß wÂ ›ew" ›cLeM 'u`::$	*"During my mother's long illness, I used to sit alone at home, think and worry for long."*
#□", □T u'u[‹uƒ Ñ>²? ŸQSTE uLÃ ¾T>ÁeÚ"nƒ ¾— ¾MÐ□ Ñ<ÇÃ 'u`:: MÐŠ U" ÃJ'< ÃJ";□ÁK‹ e□ew" eƒÚ'p □'@ u×U □[ui 'u`:: w‰Â" ›Kpe 'u`:: QSTE Ö"„ ¨Å Je‹úM c=¨eÇDƒ ›ƒÚ'l ›Ã³D‹G< wL" 'u`:: □'@ Ó" u×U ›KkeŸ<:: }eó q[ØŸ<:: ŸØmƒ k"ƒ u%Ł'□‹" V}‹::$	*"I used to feel very sad during my mother's illness because she used to worry and complain so much. She used to say, 'who will look after my children?' and sometimes she would cry. I would also start crying. The day she was taken to the hospital she told us not to worry. I was crying deeply. She stayed in the hospital for a few days then she died."*
#ŸƒUl`ƒ u?ƒ ¨Å u?ƒ uUS×uƒ Ñ>²? G<K< ›v," u›MÒ LÃ }˜„ uQSU c=cnÃ T¾ƒ" u}KÃ ÅÓV ¾ÕÅ™Š ›vƒ Ö?'— J'¨< c=Ñu<" c=¨Ö< T¾ƒ K□'@ ß"kƒ" YnÃ 'u`::$	*"What hurt me most was finding my father lying in bed after coming back from school while my friend's fathers would be moving here and there looking healthy."*
#□",U J'‹ ›v, □S¬ u'u[Ñ>² u□U ÃÚ"k– 'u`:: c=V~ ›Mku`"D†¨<U U¡"Á~U ²SÊ‰†¨< ŸKŸK<˜:: ü□SS< Ñ>²? □'"'D" Jeú□M N?Î MÖÃn†¨< wðMÓU . . . (}"Ò]ª u×U eLKkc‹ ØÁo¨<" ›MkÖMŸ<U)	*"When my parents were sick, I felt grief. When they were taken to be buried, relatives took me away. I wanted to visit them while they were in the hospital, but----." (Broke off in tears so that I stopped probing).*
#¨LÐŠ ¾'u^†¨⊴"¡w"u? G<K?U ¾U[d¨< ›ÃÅKU:: ö„-Ó^ó†¨<" v¾G<ƒ lØ` □[uhKG<:: □Ú'nKG<:: U `` wÂU ›KpdKG<:: ö„Ó^ó†¨<" }SM¡Š¨< U"K vMV~; vÃV~ •a□¢. . .$ (}"Ò]ª u×U eLKkc‹ ØÁo¨<" ›MkÖMŸ<U)	*"I remember how they used to take care of me. I always felt sad when I looked at their pictures. Look at the picture. I wish they had not died. If they---"(Broke off in tears so that I stopped probing).*

The reflections of some of the participants mentioned above clearly indicate that the child household heads in the study were living in traumatic living conditions. They have faced severe socioeconomic and psychological (emotional) problems.

Many problems the children related centred on household economic security issues. All the study participants related stories of serious economic insecurity. The results are consistently

similar with all study participants experiencing severe difficulties acquiring sufficient food, providing access to education and health care and often time having problems of providing shelter.

Child household heads spent much of their time looking for casual work to provide adequate food for the household and managing the meagre food supplies. If they were fortunate, the child household heads survived on up to 150 birr per month, however, often times they had much less than that. This has created serious problems for the child household heads in the study in providing the basic necessities for their siblings. This clearly demonstrates the child household heads in the study face the biggest economic challenge, a reflection of, perhaps, the economic hardships facing the majority of orphan children in Ethiopia.

Additionally, they expressed considerable worry about their own health and that of their dependants. Many comments were made about becoming sick and lack of sufficient money to provide access to appropriate medicine and health care. They were concerned about their ability to care for ailing siblings. Most had some siblings who were sick and were often unable to provide any health assistance to such a sick child.

The few resources that could be used for education, food and health care, is diverted to providing shelter. Child household heads have problems finding money to pay for accommodation, sometimes having to make choices between buying food and paying the rent. In fact, they have been supported by NGOs in the form of food and other materials, but such supports were sporadic and insufficient compared to the severity of the problems they have faced in their day to day activities in their households. Equally important was that some of the child household heads have received skills training with the support of NGOs in the belief that the training will enable them to get employment opportunities to earn a living of their own and their households in a consistent manner. Despite the training however, none of them had employment opportunities. This might be because the skills training that these children have been given has saturated the market or the skills training has been provided with little consideration for the children's preferences, interests and choices. The outcome of

this situation may provide insight to the service providers, especially NGOs, pertaining to skill training in their planning and intervention mechanisms.

Beyond the economic hardships, the psychological (emotional) problems were also evident among the child household heads in the study. The stories of children, regarding illness, may provide some of the more descriptive narrations of the impact of HIV and the AIDS epidemic on individuals, particularly children of their age. As the children described the times they spent with their ill parents, they frequently used words like pain, sadness and deep rooted hurt to describe how they felt. In addition, the children related stories of hope and tears during their parents' illness. They recurrently spoke of crying and described feelings of extreme anguish when they had to watch their parents suffer from the illness.

The word 'suffer' was used frequently when describing their parents' conditions – both in terms of their own emotions, but also in terms of that of their parents' physical and emotional state. They also described feelings of extreme sadness while caring for their ill parents when other children were returning home from school to parents who were healthy. The children remembered how worried they were about their mother and/or father passing away. They worried about who would care for them and love them as much as their parents had done.

Many children talked about their worries of the illness and the death that comes with it. It appears that the frequency of illness and death is having some type of emotional and psychological impact on the children. The long term experience of parental illness and eventual death were having a harrowing impact on the child household heads in the study.

5.1.5. Being a Head of Household: Strategies for Coping

Participants in the study reported that they had used different strategies to make them free from grief, pain and problems. Religious activities and friendships are salient themes in this regard.

Prayer and going to church have played an important part in the lives of many of the respondents in the study.

#ß"kƒ“ SØö eT@ƒ u}cT˜ Ñ>²? G<K<" □çMÁKG<:: ŸçKÃŸ< u%ELU ¾S[ÒÒƒ eT@ƒ ÃcT—M::$	*“I pray when I start feeling bad, I feel much better and calmer after pray.”*
#SØö eT@ƒ c=cT˜ }"u`¡Ÿ? □çMÁKG<:: ¨Ç=Á¨<U u¨LÐŠ LÃ ¾J'¨<" G<K< □[dKG<:: □Ó²=›wN?`" G<K? ›euªKG<:: ŸenÃU Á¨×—M::$	*“Whenever dark thoughts invade me, I sit down and begin to pray. Suddenly I found myself forgetting about what happened to my parents. I put God first. That is how I overcome my grief.”*
#G<K?U u?}¡`e+Á¼N?ÉŸ< □çMÁKG<:: ‹Ó_"U K□Ó²=›wN?` □'Ó[ªKG<:: Ÿ²=Á u%EL U"U ›Ã'ƒ enÃU J' ß"kƒ ¾KU::$	*“I always go to the church and pray. I take all my problems to God. No grief and no pain at all.”*
#u?}¡`e+Á" ›v„‹ SêNõ pÆe" Áe}U\—M:: Vƒ KT"U ¾TÃk` □SJ'<" —U □"ÅU"Vƒ Ã'Ó\—M:: Ÿ²=ÁU cLU ÃcT—M:: Ÿ¨LÐŠ Ò`U □ÅU"Ñ"˜ ›¨<nKG<::$	*“People from the church used to come and read the Bible with me. They used to tell me that death is inevitable and that all of us will die. They used to encourage me and I would feel a lot better after talking to them. I know we (I and my parents) will meet in heaven.”*

Some reported that being with friends – who are orphan children themselves – and away from the home environment provided them with the space and time to forget about their pain and problems.

#c=Ú"k˜ u×U ›KpdKG<:: Ÿ²=ÁU ¨Å ÕÅ—Â u?ƒ□H@ÇKG<:: ÕÅ —Â □"Å □'@ ¨LÐ‹ª V}ªM:: □ê"“—K‹:: ƒS¡[—K‹:: Vƒ KT"U ›Ãk`U ƒK—K‹:: ŸS}—, uòƒ SçKÃ □"ÇKw˜ u}ÅÒÒT> ƒ'Ó[—K‹:	*“I cry when I feel sad and after crying I go to my friend. My friend's parents are both dead. She consoles me and tells me that death is inevitable. My friend also tells me to pray everyday. She tells me that I should*

□'@U eçMÃ □öÃ□ ›Ñ—KG<::$	*pray before I go to sleep so that I do not think about my parents so much. I find praying helps me a lot."*
#ŸG<K~ ÕÅ™Š Ò` Ÿu?ƒ ¨ØŠ eÝ¨ƒ ¾T>cT˜" ¾YnÃ eT@ƒ □[dªKG<:: }SMg? ¨Åu?ƒ eÑv ¾en¿ eT@ƒ ÃcT—M:: Ÿ²=ÁU □çMÁKG<::$	*"I used to feel better when my friends – who are orphans- took me to play with them. When I came back, the grief was there until I prayed."*

In general, praying and playing with friends were the main coping strategies taken up by all the child household heads in the study during and after the parents' illness. Prayer was probably the most important coping strategy for most child household heads.

It was also interesting to see that the children in the study have preferred playing with friends who were orphan children themselves in order to cope with their grief and pain. In possible explanation, this was because they were having something in common to be shared, that is death.

5.1.6. Being a Head of Household: Views on the Future

Most of the participants in the study accepted that this is their role for life. They had no expectations of either rejoining the extended family or being taken in by another family.

#uu?}cw □Lò', □kØLKG<:: U¡"Á~U T"U ²SÉ "Kñƒ Zeƒ ¯Sƒ ËUa U"U ÉÒõ" □`Ç□ ›LÅ[ÑM˜U::$	*"I will continue being the head of the household because it has been three years without any relatives taking any of the children under their care."*
#T"U ²SÉ" ¨ÇÏ"Ç=S¡[˜" ÉÒõ □"Ç=ÁÅ`ÓM˜ ›MðMÓU:: Ÿ¨"ÉVŠ" Ÿ□I„Š Ò` □ eŸ›G<" •["M:: ¨Åòƒ U ›w[" □"•^K":: □Ó²=›wN?` Ÿ□— Ò` '¨<::$	*"I do not have anyone to advise me or who can assist me keeping the young siblings or me. I have remained with my siblings. We will continue keeping ourselves, God is with us."*
#□'@ uuŸ<K? ²SÉ u?ƒ N?Î S•` ›MðMÓU:: □"□‹" ŸV}‹ ËUa [e}¨<"M:: ›G<" ƒMp '˜:: ¨"ÉVŠ"" □I„Š" Te}ÇÅ`	*"As for me, I do not expect to be kept by relatives in the future; we are alone, because they failed to keep us soon after the death of my parents. Now that I am so much older I*

□‹LKG<::$ *can take care of my siblings."*

One respondent talked of the relatives not even attending his mother's funeral. Culturally, this would be unheard of. Reflections of the children in the study on views for the future seem to mirror the reality for the collapse of the extended family support systems.

To sum up – in this section, I have briefly analysed the main themes of the stories/reflections of the child household heads in the study on the roles and challenges of household care giving efforts.

In the following section I will discuss the stories/reflections of their siblings gathered from the focus group discussion (FGD).

5.2. Perceptions of Siblings in Child Household Heads

In addition to the face to face interview with the selected child household heads in the study, focus group discussions (FGD) have been held with siblings of the child household heads. The aim of the FGD was to understand the nature of the relationship of hierarchy that existed in the household, the relationship between brothers and sisters and to obtain a broader picture of their day to day life. The FGD has been held in two rounds and a total of 10 children – 3 boys and 2 girls in the first round while 2 boys and 3 girls in the second round drawn from the selected child household heads – took part. The FGD participants fell into the age range of 12-15 years.

This section presents the reflections/stories of children in FGD. Most importantly, it reflects the perceptions of siblings towards the local community, their deceased as well as existing caretakers (child household heads), the day to day problems and their views on the future.

5.2.1. Perceptions of Siblings towards the Local Community

Analysis on the perception of orphan children towards the local community reflects the local responses and gaps to address the problems of orphan children. In an attempt to understand the social relationship of siblings with their immediate communities, participants in the study were asked to list any name calling related to their status of being an orphan by people in their communities.

Most of the participants perceived that people in their communities (especially neighbours and friends) had sympathy towards orphan children. Participants reported that they have often been supported with food and other educational material such as exercise books by neighbours and friends. This indicates the community response to the needs of orphan children is not only promising but also reflects a level of acceptance of these children after the death of their parents.

Despite support from neighbours and friends however, almost all the participants have constantly mentioned the experience of mistreatment, neglect and exclusion by the *relatives* of their deceased parents. The testimony of one FGD participant describes the effect as follows:

#□“□‹” ŸV}‹ ŸZeƒ ¨` υ%EL ›¡e□‹” □’@” ¨cÅ‹˜:: ›¡e, Gw□ U “ƒ UÓw υ?ƒ ›Lƒ:: eƒ¨eÅ˜ nM □Ñ‹w˜ ’υ`:: ƒUl`ƒi” ›e}U`hKG<' G<K<”U ’Ñ` ›Å`ÓMhKG<:: ›Ãµi wL˜ ’u`:: Ÿ¨cÅ‹˜ u%EL Ó” ¾u?ƒ W^}— ’¨< ÁÅ[Ñ‹˜:: ƒUl`ƒi” uT>kØK¨< ¯Sƒ ƒT]ÁKi:: ›G<”□²=l x□ ¾KU ›K‹˜:: G<K<”U ¾u?ƒ Y^□’@ ’υ` ¾UW^¨<:: ¾’c<” Mwe ›Ø□K□Ë^<:: □ÒÓ^KG<:: υn ›K ›ÃÅM G<K<”U □W^KG<:: vLD ÅÓV G<M Ñ>²? . . . Ÿ³ . . . □“□‹” wƒ•` •a Ó” . . .$ (}“Ò]ª Ÿ[ÏU ´U□ υ%EL ”ÓÓb” ›s[Ö‹::)	*“Three months after the death of our mother, my aunt came and took me to her home. My aunt is rich. She has a restaurant. She promised education and other support when she took me to her home. However, I found myself as a housemaid in her house I did all the housework. I baked Injera[12]. I washed clothes etc. Her husband always-------- then-----. If my mother were alive-----”(kept silent for long and discontinued her reflection).*

[12] Local traditional bread and staple food in Ethiopia.

This contracting behaviour between relatives and neighbours is interesting. It seems that certain people may extend a helping hand as long as they do not have to take all responsibility upon their own shoulders.

5.2.2. Perceptions of Siblings towards Their Deceased Parents

In trying to ascertain the changes that occurred after the death of their parents, children in the FGD were asked to reflect on their life by comparing life before and after the death of their parents. It transpired that three children (one boy and two girls) had no memory of their deceased parents because their parent(s) has/have passed away in their early childhood. Also, one participant was uncomfortable to reflect on the issue. The reflections of some of the children among the remaining FGD participants on the issue are as follows:

#¨LÐ‰‹" ŸV~ ËUa G<K<U 'Ñ` }K¨<×DM:: ¨LÐ‰‹" G<K<"U ÉÒõ" □''¡w'∪? ÁÅ`Ñ<M'' '∪`:: ŸC∂` ÕÅ™‰‹" Ò`□ Ý¨ƒ '∪`:: ∪×U Åe} — 'u`Ÿ<:: ŸƒUl`ƒ u?ƒ eS× UdÂ }²ÒÏ„ ÃÖwk—M:: ›G<" Ó" ›w³—¨<" Ñ>²? Uk" ›"È □''∪LK''.. .::$	*"Things changed from the time our parents died. They used to give us support. We used to enjoy playing with our friends; I was a happy person. When I went home from school, I would find my lunch ready. Now, from the time my parents passed away, things changed. We sometimes eat once a day now--."*
#¨LÐ‹l c=• \ ¾ðKÓ¤¨<" □Ñ—Kl:: õp` □Ñ—Kl:: un ›K ›ÃÅM ¾Ö¾pŸ¨<" G<K< □Ñ—Kl:: ¨LÐ‹l" T×ƒ SŸ^ '¨<:: enÃ '¨<:: un... un. . .::$ (u□''v }s`×DM)	*"When your parents are alive, you will get the love and material support that you need, and whatever you ask for. Losing one's parents has brought so much misery-----so much----so."(Broke off into tears).*
#¾¨LÐŠ Vƒ u×U '¨< ¾Ñ□Ç˜:: ¨LÐ‰†¨< ÁK< ÕÅ™Š . . . un M□Å†¨< c=Ÿu` eÙ□ ÃÑ³L†ªM& K□'@ Ó'' T''U ¾T>Ñ³M˜ ¾KU:: ›G<"::$	*"I do not feel nice (about the death of my parents) because you find that your friends (who have) both parents ------ when it is their birthday, their parents buy them presents. Now with me, my parents are not there to buy me any presents."*
#uu¯Lƒ Ñ>²? ¨LÐ‰‹" ›"Ç"É Ñ>²? ›"Ç"É Ñ>²? ÅÓV ¾}KÁ¿ 'Ña‹ ÃÑ²<M" 'u`& . . . □", ¾'@ T`' ¾'@ "Óeƒ□ÁK‹ . . . ::$ (Kpf)	*"Our parents used to buy gifts during holidays------my mother used to call me 'my honey, my princess-------." (Stopped talking and kept silent for long).*

The reflections above demonstrate that life for most children in FGD has changed since the death of their parents. They experienced the lack of basic human needs since the death of their parents. The decline in the standard of living in their households after the death of their parents was also demonstrated repeatedly by the participants (child household heads) in the study. It was also interesting to see that beyond the limited access to basic needs, children in FGD were all aware of their need for parental love and affection after the death of their parents.

5.2.3. Perceptions of Siblings towards the Existing Care Takers (Child Household Heads)

All the siblings in the study were taken care of by an elder brother or sister. The siblings expressed that a specific sibling assumed parental responsibilities since the illness of their parents and continued to do so after their parents' death.

Though living in abject poverty, it has been found that the perceptions/attitudes of siblings towards their existing care takers were generally positive. This can be seen in their expressions of such words as *reverence, shared responsibility, and empathy.*

Reverence:

#uòƒ □"□‹" ∪'∪[‹ Ñ>²? ∪×U '∪` ¾U"cÇÅu¨<" ¾U"×L¨< ›G<" Ó" u×U '¨< ¾TŸw^ƒ:: ¾UƒK˜" G<K< □cT□KG<::$	*"Before the death of our mother we (she and her elder sister) used to fight both verbally and physically. Now I do respect all her words. You see, she dropped out of school and does all the work she can get for our survival. "*

Shared responsibility:

#□c< Y^ c=H@É □'@" □l„Š G<K<"U ¾u?~" Y□"W^K":: MwdD"U □"ØwK□K":: □c< É¡U wKAƒ c=S× u?~ }e}"¡KA" }çÉ„ c=Á¾¨< u×U Åe ÃKªM:: □c< c=Åcƒ e"Ã □—U Åe ÃK"M::$	*"When he goes to work, we (he and his sisters) do all the housework. We also wash his clothes. He usually comes home tired, but when he sees our home clean he becomes very happy. When we see his happiness we also become very happy "*

Empathy:

#¨”ÉT@ uƒUl`~ u×U ÑAu´ ’u`:: K— wKA ƒUl`~” ›s`Ù ›G<” ¾k” Y^ ’¨< ¾T>W^¨<:: u×U ’¨< ¾T>Ád´’˜:: u×U ›eW×K K^c? nM Ñw‰KG<:: }U□’@¼“ ¾c<” QÃ¨ƒ KSK¨Ø:: uƒUl`, ÑAu´ }T] ’˜:: ›”Å— ’¨< ¾U¨×¨<::$	*“Before the death of our parents, my brother used to be good at his education. He dropped out of school since the death of my mother and do casual work now so that we (I and two of my sisters) are able to continue with our education. I always sympathize deeply with his soft-heartedness to support us since the death of our parents. I promised myself to be successful in my education and to change his life. I am very good at my education. I always score high marks.”*

These reflections presented evidence for not only the positive perception of siblings towards their sibling caretakers but also the appreciation for the strong commitment the child household heads have made for the survival of the households. This shows that siblings had generally positive attitude/perception towards their eldest sibling – child household heads.

5.2.4. Day to Day Challenges: Problems versus Perceived Needs

Many questions related to problems faced centred on household economic security issues. The results are similar with all study participants experiencing severe difficulties with education and health care and most importantly having problems of shelter. The provision of such services are found to be the most pressing and prevents them to live their days healthily, installing hope for the future and the worth of an individual life. In fact, these issues were also mentioned repeatedly by the individual research participants (child household heads) of the study.

Most children in the FGD mentioned the significance of the financial support – in the form of cash to be paid on monthly basis - that enables them to cover their house rent. This support, they said, may protect them going out to the street or from having the ‘same bad fate’ of other children due to the lack of assistance from any sources. In support of this fact children in FGD have presented the cases they experienced in their localities:

#›"É u›?‹.›Ã.y=/›?Ée ¾}ÑAÇ u?}cw ›¨<nKG<:: ¨LÐ‰†¨< □¾□SS< c=¨Ö< ¾u?}cu< Ñu= u×U □¾k'c S×:: dÃ□SS<U uòƒ ¾u?}cu< Ñu= u×U ƒ"¡ 'u`:: u›"É ¯Sƒ Ñ>²? ¨<eØ G<K~U ¨LÐ‹ V~:: Ÿ²=ÁU G<K~U Ÿ²=ÁU G<K~U c?„‹ MÐ‰†¨< KŸõ}— ‹Ó` }ÒKÖ<:: □'–>I MÐ‹ u□— □ÉT@ ÁK< ‘'†¨<:: U"U ¾T>[Ç†¨<“ ¾T>ÅÓó†¨< ²SÊ‹ c=ÁÖ< u<“ u?ƒ ŸT>W\ K?KA‹ c?„‹ Ò` ÕÅ˜'ƒ SW[~:: u%ELU □'c< ^d†¨< u<“ u?ƒ SY^ƒ ËS\:: Ÿ²=ÁU ¾¨LÐ‰†¨< □ÉM ÑÖT†¨<::$	*"I know a family which was affected by HIV/AIDS. During the illness of the parents the family income worsened. Even before the illness they were living in a very bad economic situation. The parents died within a year of each other. After the death of their parents, the two children faced serious problems. These girls were our age. As they did not get any close relatives to support them, they were forced to have friendship with those girls working in the street and bars. Gradually they became engaged in prostitution at an early age which caused them to suffer the same fate as their parents."*
K□ ‘~ Ò` w‰ ¾T>•` ›"É ¾²Ö˜ ¯Sƒ MÏ 'u`:: □‘~ K[ÏU Ñ>²? Ÿ□SS< u%EL V~:: □ ‘~ ¾V~ƒ u›?Ée '¨< ÃvLM:: MÌ T"U ¾T>[Ç¨< ›M'u[U:: ¾u?ƒ Ÿ=^Ã ¾T>ŸõMKƒ c¨< c=Á× ¨Å ÑAÇ“ ¨×“ T@¡c=¢ ›"vu= "K< ¾ÑAÇ“ MÐ‹ Ò` }kLkK:: ›"É k” ¾}kÅÅ Mwf‹ ›É`ÑA ›ÃŠªKG<::$	*"I know a nine year old boy living with his mother. His mother, after suffering from illness for a long time, died in her house. The cause of her death is said to be AIDS. The boy lacks anyone to support him for his house rent which forced him to leave the place and live with street children in Mexico[13] area of the town. I have seen him one day wearing a very dirty cloth."*
#Ÿ13-17 ¯Sƒ ¾T>J“†¨< ¨LÏ ¾K?L†¨< c?ƒ MÐ‹” □‘'¨<nK":: □'–>I MÐ‹ Ñ"²w KTÓ–ƒ c=K< ŸƒLMp ¨"Ê‹ Ò` Ó"–<'ƒ ›L†¨<:: ¨Å ÑAÇ“ ¨× wƒM ¾}KÁ¿ ¨×ƒ c?„‹ ¾cŸ[c¨ KTÓ–ƒ ¨Ç=Á“ ¨Ç=I c=µ\ □ÁKl::$	*"We know some orphan girls of age 13-17 who were forced to have sex relations with adults to get money. Even if you go around the asphalt road you can watch teen-age girls wondering here and there specially in alcohol drinking places to find drunkards."*

It seems that they compare themselves with children who are "worse off" than them in order to console themselves.

5.2.5. Views on the Future

[13] This place is one of the central areas in the city of Addis Ababa.

The final theme from the FGD was to ask siblings in the study to reflect on their aspirations for what they would like to be in the future. Some of the responses are as follows:

#Êi}` SJ" □ðMÒKG<:: Ui"Á~U □", ›"ˆ Êi}` J'i c-‹" TŸU ›Kwi ƒK˜ 'u`::$	*"I want to be a doctor, because my mother used to tell me that 'I am a good girl to become a doctor and help sick people'…."*
'ÒÈ SJ"□ ðMÒKG<:: ƒMp ¾"ÓÉ }sU •a˜ ¨"ÉVŠ"“□I„Š¼' '<α SK¨Ø □ðMÒKG<:: ¾T>ðMÑ<ƒ" G<K< ›Å`ÓL†ªKG<::$	*"I want to be a business man so that I can establish a big firm and take care of my family, giving them all that they need: a house, clothes and food."*
#›e}T] J'@ □"Å'@ ÅG ¾J'< MÐ‹" Te}T` □ðMÒKG<::$	*"I want to be a teacher so that I educate poor children like me."*
'`e J–@ ÅG c-□SSc= S`Çƒ □ðMÒKG<::$	*"I want to be a nurse so that I help sick people with no money---."*

Views of the siblings for the future that showed their aspirations of becoming a 'doctor', 'nurse', 'teacher' and so forth signifies siblings understanding and realization of the value of education as a key factor for they are able to escape poverty and have a better future.

In general, running away from home was not a salient issue for all the research participants – both the child household heads and their siblings – despite living in abject poverty. There has been a strong commitment of many of the child household heads to look after their siblings both now and in the future. The stories of the siblings have also reflected the same that they have been committed to bring changes for a better life. On top of this, siblings did respect the words of their existing care takers – child household heads. For example, though sibling rivalry was common when their parents were alive their relationships are more often characterised by cooperation after the death of their parents, for example: *'before the death of our parents, we used to fight each other, but now I do respect all her words'*(from one FGD participant). This reflects that none of the research participants showed any inclination to become involved in anti-social behaviour despite their hardships. The severity and

magnitude of their poverty does not necessarily drive an individual (especially the children in this study) to involvement in anti-social behaviour.

To sum up – in this section, I have made attempts to analyse the stories/reflections of the children in FGD. In the following section, I will discuss the social support mechanisms that are available to assist these households to cope with the challenges they have faced. Most importantly, it investigates the role of children-focused NGOs to promote the wellbeing of children in these households.

5.3. The Role of Children-Focused NGOs

Attempts have been made to examine the approach by NGOs in the study area with the aim to understand the social support mechanisms that were available to assist child household heads to cope with the challenges they have faced.

In this regard I have conducted semi-structured interviews with three key informants drawn from children-focused NGOs that were providing care and support services to OVC through home and community based approach (see Addendum A, III). Equally important was that all the documents believed to be important for the topic of the study have been reviewed in order to assess the existing community based care and support services made available to OVC.

The children-focused NGOs have been selected in terms of their capacities (geographical coverage). During the time of the interviews these organizations worked with 68 local governmental institutions (Kebeles[14]) and 210 CBOs (Idirs[15]) in all the ten sub-cities of Addis Ababa.

[14] Kebeles are the smallest political administrative units in the government structure of Ethiopia. Sub-cities are also government administrative unit next to Kebeles. Addis Ababa is divided into 10 sub-cities and there are 10 to 15 Kebeles under each sub cities.

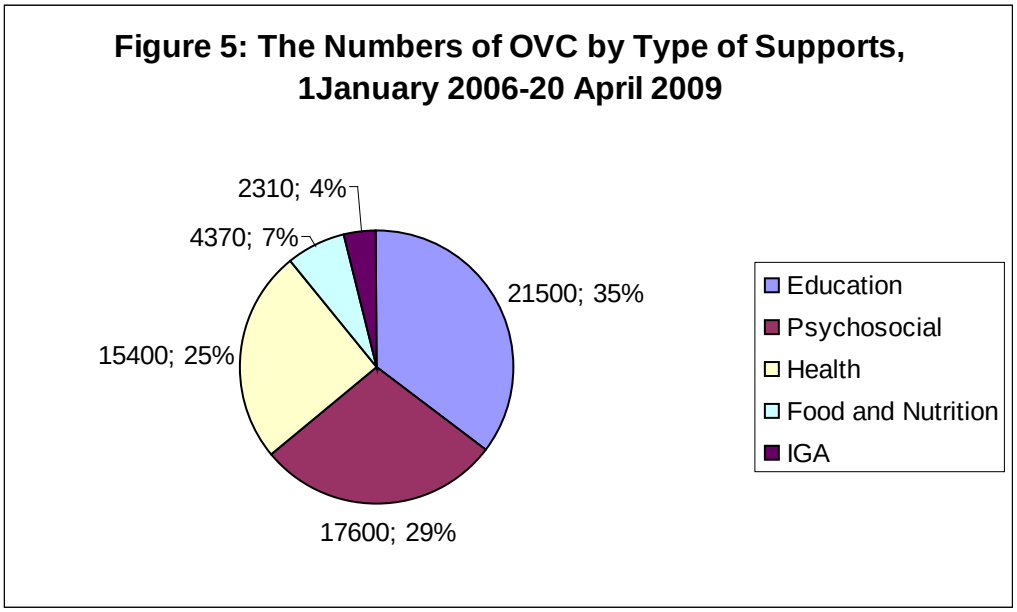
[15] '***Idir***' is a social institution whereby a group of people comes together on the basis of location, occupation, friendship or family ties. Members contribute a certain amount of membership fee on a regular basis and the money is deposited in banks or kept at one of the member's house. Each Idir sets its own rules and regulations but usually pays out for funeral expenses or financial assistance to families of the deceased, and sometimes to cover other costs, such as medical expenses and losses due to fire or theft. Virtually all Ethiopians are members of one or more idirs.

This section mainly focuses on exploring the needs and relevance of the care and support services rendered by the children-focused NGOs in the study.

5.3.1. Addressing Needs of OVC by Children-Focused NGOs

The selected children-focused NGOs generally provided support to OVC in the form of educational support, psychosocial support, health support, food and income generating activities (IGA). Data obtained from these organizations, since 1 January 2006 until the time of the interviews, indicated that close to 61 800 OVC have been provided with one or more of these forms of support. As can be seen in Figure 5, of this number close to 35%, 29% and 25% of OVC have been reached with the educational, psychosocial, and health related support forms respectively. Only 7% and 4% of OVC respectively have been provided with food and IGA support. This indicates that the children-focused NGOs in the study have given high attention to meet the educational, psychosocial and health needs of OVC. The remaining needs of OVC, such as food and IGA have received little attention by these organizations.

Figure 5: The Numbers of OVC by Type of Supports, 1January 2006-20 April 2009



(Source: Reports of the Children-Focused NGOs, 1 January 2006-20 April 2009)

The educational support interventions by the children-focused NGOs in the study have been provided in the form of schooling fees, school uniforms, tutorial support, non-formal education, and educational material to children.

However, most forms of educational support were focused on interventions that did not require continuous follow up of OVC on a daily basis. As indicated in Figure 5 above, a total of 21 500 OVC received educational support mainly in the form of school uniforms and schooling fees that were provided to around 72% of the children. A slightly lower proportion of children were incorporated under interventions that require relatively continuous follow up such as tutorial support (18%) and participation in non- formal educational programmes (9.7%). Only a few children were supplied with school material (10%).

The provision of psychosocial support have been given in the form of counselling, home visits, recreational support and spiritual guidance, peer education, and succession planning.

As indicated in Figure 5 above, close to 17 600 OVC have been reached by the children-focused NGOs. Of this number, close to 68% of children were receiving one or more types of support in the form of counselling, home visits, recreational support and spiritual guidance. Slightly lower proportions of children have received psychosocial support in the form of peer education (18%) and succession planning (14%).

Health related support was one of the major interventions carried out by the children-focused NGOs in the study. In reference to Figure 5 above, about 15 400 OVC were receiving health related assistance. Of this number, about 79% of OVC received health support in the form of medicine. About 13% and 6% of them took part in HIV/AIDS awareness raising as well as hygiene and sanitation support respectively. Nearly half of the children have obtained reproductive health support, while a few received VCT services (2%) and ARV treatment (1%).

The food support by the children-focused NGOs in the study centred on providing supplementary feeding and food rations to address the immediate food needs of OVC, a

safety net type of programme. Unlike other forms of OVC support, a child does not receive more than one form of food support.

The income generating activities were often designed to meet the immediate needs of OVC. The support has been provided in the form of small grants to individuals to carry out petty trading activities after the completion of the vocational and skill training. As indicated in Figure 5 above, only 2 310 OVC have received IGA support. Further evidence was not readily available – especially the number of children who were able to earn an income of their own either by opening up their own businesses or creating self employment opportunities as a result of such an initiative.

In general these organizations have designed five intervention programmes: education, psychosocial, health, food and IGA and address a considerable number of OVC in their respective target areas of Addis Ababa. However, looking at the number of OVC reached by the type of support/programmes, one could find significant differences. Of all the support, the children-focused NGOs have mostly concerned themselves with the education, psychosocial and health needs of OVC. The remaining programmes such as food and nutrition and IGA have received relatively low attention.

5.3.2. Relevance of the care and support services

The relevance of the care and support services of the children-focused NGOs in the study have been assessed with the aim to understand the organisational policy and strategic design mechanisms that these organizations have made to address the needs of OVC. It specifically focuses on exploring the attempts the children-focused NGOs have made with regards to the programme planning, management and implementation activities in relation to the perceived needs of OVC.

5.3.2.1. Beneficiary Selection Criteria: Who are OVC and Child Household Heads?

The key informants have been asked to give the operational definition that their current work place organizations have used for OVC and child household heads in general.

The answers of the key informants revealed that the children-focused NGOs in the study had similar definitions of the concept orphan as a child below 18 years of age who lost one or both parents due to various causes including the AIDS epidemic. The key informants pointed out that their organizations did not intend to differentiate between orphans due to AIDS and other causes in order to avoid any form of stigma and discrimination against orphan children who lost their parents due to the AIDS epidemic.

With regard to vulnerable children, the following definitions have been used by the children-focused NGOs in the study:

- Children who are between the age of one month and 18 years and lacking or missing basic needs (food, health care, shelter, clothing, education, love and affection and familial protection);
- Children with disabilities;
- Abandoned children;
- Children exposed to different forms of abuse and neglect;
- Children living in the street; and
- Children who have no one to take care of them.

It is interesting to see that the children-focused NGOs in the study have defined OVC with consideration of different socioeconomic contexts. In terms of age, these organizations have identified orphan children according to the agreed upon international definition set by CRC and the constitution of FDRE given for a child. In relation to the status of orphans, these organizations have considered single and/or double orphans who lost their parent(s) in all causes including the AIDS epidemic. It was also clear that the definition of vulnerable children has been overwhelmingly related to the demand of the socioeconomic security of orphan children.

Despite the emphasis on OVC, the concept child household heads have received less consideration to be defined by these organizations. During the interviews, all the key informants have expressed their view of having little or no information as to the child household heads. One of the informants even revealed he was unfamiliar with the term of child household head. The remaining informants have confirmed the fact that their organizations have addressed orphan children with no surviving parents under the category of 'older and school drop out OVC'. This reflects the reality that the lack of information available on the subject masked the specific nature of the challenges facing child household heads, as well as the special support they need, and their plight has not been sufficiently appreciated by service providers such as the children-focused NGOs in the study.

5.3.2.2. Participation of the local community in planning, management and implementation activities

The participation and involvement of the local community, including the beneficiary (orphan), in programme planning, management and implementation endeavours of the service providers (such as NGOs) are believed to be central to provide effective home and community based care and support services to the disadvantaged and hard to reach population segment of the society, such as OVC and child household heads.

To this end, the key informants have been asked to reflect the degree to which their current work place organizations have been committed to consider the local community participation in its programme planning, management and implementation endeavours. The reflections indicated that the children-focused NGOs have hardly offered opportunities for the participation of the local community during programme planning. As reported by one of the key informants, this was because of the fact that '*these organizations are highly bounded by the accountability demands and/or procedures of the donors*'. While the mission statements of these organizations identified the beneficiary as their primary stakeholder, the reality for them was that organizational survival was dependent on satisfying donor(s) expectations – their funding agencies. This indicates that the fundamental power asymmetry inherent in such relationships – between these organizations and their funding agencies –

ensures that the children-focused NGOs comply with accountability requirements of their funding agencies in order to engender their ongoing support – the more dependent the children-focused NGOs becomes on a given funding agency, the more focused they must be in satisfying the demands of their funding agencies. As a result, the children-focused NGOs have depended on the strategies and approaches attached to their donor's funding, which often leave no room for participation from the local community and the beneficiary during programme planning.

Unlike planning however, participation of the local community, such as *Idirs* has been better by far in *programme management and implementation* endeavours of the children-focused NGOs in the study. The Idirs, through working with the children-focused NGOs in the study, have shifted their focus from attending to the dead to supporting the sick and the dying. Within the Idirs, a small team of elected members, who are all volunteers themselves, work with these organizations to recruit volunteers, identify beneficiaries and are involved with every step of the implementation and running of their programmes. The Idirs provide the intimate knowledge of the community and the children-focused NGOs provide the technical assistance and human resources to make their programmes a success.

The key informants have also been asked about their views on the significance of the local community participation in any community development intervention programmes/ projects. A summary of their reflections are as follows:

- It helps the community to identify the right beneficiaries and to access them with their felt needs;
- It ensures avoidance of duplication of assistance and to distribute support to those who are not reached by any other programmes;
- It helps the community and the target groups to really know what services are available from the organization; and
- It helps to ensure local ownership, thereby contributing for the sustainability of the project.

The reflections of the key informants above underline the significance of the 'bottom up' approach for the success of community based initiatives.

5.3.4. Major Programme Limitations

As part of the data collection process, the key informants in the children-focused NGOs were asked to report on and describe the major gaps they have confronted in the course of programme planning, management and implementation. Based on these responses, the major service gaps among the children-focused NGOs in the study are broken down into four key issues. These include:

- **Absence of clear policy direction**

The key informants argued that there have been no organized and concrete actions to address OVC in Ethiopia. As a result of this, most of OVC programmes were fragmented and lacked a holistic approach beyond meeting survival needs, which in turn fosters the dependency of children and their hosts. At the same time, the key informants stated that there was little or no support from the concerned government bodies at various levels. Many of the government offices, for example the sub-city offices in Addis Ababa, had no adequate involvement in OVC programmes implemented by civil society organizations. This has created problems to have adequate information on '*who is doing what'* to ameliorate OVC problems and to address the strategic and practical needs of orphan children.

- **Funding constraints**

Funding was a great concern and a prevailing problem for the children-focused NGOs in the study. The key informants have cited fund shortages as their top constraint in meeting the basic needs of OVC at a minimum level. Often these organizations have relied on a single donor and as a result, many of these programmes were underfinanced. Sometimes funds ceased without the knowledge or consent of the programme implementers. Also, programmes were usually focused on meeting donor's requirements rather than the targeted recipients. Funding limitations did not only limit expansion of OVC services, but also limit

an organization's ability to enhance their capacity to plan and implement programmes that have a long lasting impact on the lives of children.

- **Absence of strong networking**

Effective responses to the OVC crisis can not be managed in isolation. There should be a concerted effort from all stakeholders including genuine collaboration among organizations working towards this end. As reported by the key informants, the children-focused NGOs in the study had some linkages with different organizations engaged in similar endeavours: as grantees, having advocacy and networking relationships with others and relationships with other organizations based on resource sharing.

The key informants also considered the absence of a strong networking forum dedicated to mitigating OVC problems as a major impediment. Lack of innovative approaches to address the OVC problem through a common strategic goal and framework was another drawback that was manifested due to limited networking and collaboration among actors.

- **Absence of comprehensive information on OVC**

Before programmes are designed and strategies are developed that target OVC, it is necessary to understand the context in which these children live and the challenges they face. In Ethiopia, there were no comprehensive studies and data available to objectively support OVC initiatives both at policy and programme levels.

Often programmes are designed without adequate research beforehand and successes are not adequately documented. In the course of this study, it was observed across all organizations that the lack of maintaining relevant information related to every OVC's background and their current status.

In general, there has been a poor programme strategic design in the children-focused NGOs in the study. These organizations lacked a clear strategy to address the root causes and respond to the outcomes of the OVC crisis in their respective catchments. As a result, they depended on the strategies and approaches attached with donor funding. They also did not have succession plans and proper behavioural guidance for the children as they move towards adulthood. Similarly, they did not start programmes or projects with well defined entry and exit strategies since their entry into and withdrawal from certain interventions were exclusively determined by donors.

Often programmes were not designed on a situational analysis and strategic needs of OVC. As indicated in the earlier section of this paper, most programmes focused on the immediate needs and symptomatic problems of the OVC crisis. Equally important was that these organizations had no official guidelines that direct the minimum requirements in the content and strategies of OVC support programmes. Agreed upon guidelines would help to ameliorate problems in providing efficient and effective support to OVC.

5. 4. Summary of the Main Themes

This chapter has been mainly concerned with data presentation and analysis gathered from the field study among the selected child household heads, their siblings and key informants by employing different qualitative data collection methods. The analysis has been made mainly to understand and ascertain the main research questions of the study: how child household heads in Ethiopia, due to the loss of their parents to AIDS, were coping with the challenges that they faced such as caring for themselves, their younger siblings and preparing for their future? And what were the existing support mechanisms that were available in order to assist these households in coping with the challenges they have faced?

The study identified the roles the child household heads have had and the challenges they have faced towards performing household care giving efforts.

I have examined the parental role the child household heads in the study have played for the sustenance of their households: the underlying causes in which they have assumed parental

responsibility; the way they perceived taking on parenting; the strategy they have used to maintain household management; and their views on the future towards headship responsibility. I have also identified the many and various challenges that these children, as head of households, have experienced while performing the day to day household tasks, including the mechanisms they have used to cope with the challenges. It was found that similar to Sloth-Nielsen's (2004) contention, child household heads take on the same responsibilities as adults.

I have also made attempts to explore the world of the siblings in child household heads. I have examined the perception of siblings towards their local communities, their deceased parents as well as their existing care takers – child household heads; the problems they have faced in their day to day deeds; the plan they had and/or aspire on the future.

The study depicts that child household heads and their siblings have experienced all forms of poverty. An inability to meet with basic household needs and necessities on the one hand and the psychological trauma of witnessing the long-standing parental illness and its consequences of death on the other hand, were evident in the lives of the child household heads and their siblings in the study.

The study also points out that, despite the multifarious challenges, child household heads have been given little attention by the policy makers in general and the service providers at large. They have been provided with some support under the grouping of OVC, despite significant differences child household heads have even under the category of orphan children. NGOs have made commendable efforts to address the socioeconomic, developmental and psychological (emotional) challenges of orphan households. These efforts are remarkable despite its limited scope.

To put in a nut shell, this study illustrates the material and psychosocial impact of the HIV and AIDS epidemic on the child household heads and their siblings, and the need to support these children. The child household heads in this study face the burden of caring for siblings

with no adult help. All of these households live in abject poverty and have little capacity to manage. Many rely on erratic casual work and the kindness of neighbours.

Chapter Six: Conclusions and Recommendations

The main research questions of this study is: *How child household heads between the ages of 12 to18 in Addis Ababa, Ethiopia, who lost their parents to AIDS, cope with the challenges of caring for themselves, their younger siblings and preparing for their future?* This qualitative study was thus aimed at ascertaining the roles and challenges of household care giving efforts by child household heads affected by HIV/AIDS after losing one or both parents to the illness. It also examined the social support mechanisms that were available to assist these households to cope with the challenges they have faced.

The study employed an exploratory research approach with a purposive sampling technique that aimed to ascertain how child household heads affected by AIDS adapted to their changed circumstances, what events meant to them, how they viewed what had happened to them and around them. The study built upon fieldwork over a period of five weeks in Addis Ababa, the capital of Ethiopia. The study gathered evidence from 10 selected households headed by children between the ages of 12-18, their siblings and key informants using in-depth interviews, focus group interviews and structured interviews respectively.

At times the research topics were emotionally taxing for the research participants. This was observed by children breaking down, unable to complete their narratives, as they related their experiences. Listening to such stories had its own negative impact on me. The effect was overwhelming at times. I had haunting memories of witnessing the children's living conditions and it had a prolonged effect on me, especially in doing the analysis of the data. I sometimes had to stop doing my analysis for long periods while the overall living conditions of the children, which I have observed during my interview, re-appeared in my mind.

Generally, the findings of study reveal the severe and traumatic conditions in which the child household heads and their siblings are living. Based on the study's findings, the following conclusions are drawn and recommendations are posed.

6.1 Conclusions

The study explored the parental roles and responsibilities the child household heads have taken upon them in an attempt to meet the household needs.

6.1.1. Being a Head of Household: Challenges

All the child household heads and their siblings lived in abject poverty. Economic insecurity is the prime concern for them that have to be resolved since they have survived on irregular casual work, insignificant support from NGOs and the kindness of neighbours. The results are consistently similar with all study participants experiencing severe difficulties acquiring sufficient food, gaining access to education and health care and often times having problems of obtaining shelter.

The study also reveals that child household heads and their siblings face tremendous emotional and psychological challenges as they live with the constant memory of their deceased parents and their lingering agony and death. The stories of the children, regarding illness and death, provide some of the more descriptive narrations of the impact of HIV and the AIDS epidemic on individuals, particularly on children of their age. Witnessing the long-standing parental illness, and consequently death, has a harrowing impact on the child household heads and their siblings in this study.

6.1.2. Being a Head of Household: Assumption, Perception and Views on the Future

The child household heads in this study took on plenty of responsibilities: work to support siblings, obtain food, clothing and shelter, and deal with the emotional wellbeing of their siblings (cf. Sloth-Nielsen 2004). Most children took headship responsibilities during a parent's illness already and continued with this role after the parent's death. They took on this role mainly for two reasons: because they were the eldest sibling in the household and as result of the collapse of the extended family support.

Despite all the hardships, taking on parenting responsibilities (or heading a household) created happiness and a sense of satisfaction for many of the child household heads. They have realized the positive aspects of being a head of household that made them happy, such as having learnt how to run a home; being praised by people, especially neighbours, about the way they look after their siblings; having become a better person, and looking after their siblings.

Equally important was that siblings had generally positive attitudes/perceptions towards their caretakers – child household heads. The reflections of the siblings that revealed reverence, shared responsibility and empathy have presented evidence for not only the positive perceptions of siblings towards their existing caretakers, but also the internal appreciation of siblings for the strong commitment the child household heads have made for the survival of the households.

6.1.3. Being a Head of Household: Household Management and Coping Strategies

The child household heads in the study have used different strategies to manage the household and discipline their siblings. Advice centred on being respectful and looking after the younger siblings. It seems that those siblings who were advised with guiding words form the existing caretakers (child household heads), value their instructions and try to live up to the expectations of their child household heads. In the case of child household heads who failed to manage the discipline of their siblings, neighbours have played important roles to instruct and advise the siblings. Housework has been divided in different ways: through delegation for many of the boy household heads and in the realm of team spirit (shared responsibility) for households headed by girls, highlighting the gendered nature of housekeeping responsibilities in the Ethiopian culture.

The child household heads have two main strategies – praying and playing with friends (children who are also single and/or double orphans) – believed to be pertinent for them to cope with their grief and pain.

It is also interesting to see that, in spite of having faced all forms of poverty, all the children in the study wanted to live together with their brothers and sisters. None of the research participants have intended to run away from home and join street life. This may imply that none of them have the tendency or inclination to get involved in anti-social behaviour.

6.1.4. The Social Support Mechanisms

Child household heads and their siblings have been supported with material aid in the form of food, educational material and health care. Educational support ranges from covering school tuition fees to buying school uniforms and educational materials. A few older children have been given vocational training opportunities by the children-focused NGOs, towards self sustaining employment. These organizations have also been active in providing psychosocial and trauma counselling services to OVC. This is a laudable effort despite its limited coverage. Unlike relatives, neighbours and friends also followed NGOs in the level of support provided, through clothing and food. Neighbours were also found to play a role in providing advice to siblings to maintain discipline and peace in the child household heads, whereas friends provided moral support.

However, the children-focused NGOs have weaknesses in their strategies to help orphan children. These organizations lacked a clear strategy to address the root causes and respond to the OVC crisis in their respective areas. As a result, they depend on the strategies and approaches attached with donor funding. They also did not have succession plans and proper behavioural guidance for the children as they move towards adulthood. Similarly, they did not start programmes or projects with well defined entry and exit strategies since their entry into and withdrawal from certain interventions were exclusively determined by donors.

Often programmes were not designed to respond to the strategic needs of OVC. Most programmes focused on the immediate needs and symptomatic problems of the OVC crisis. Equally important was that these organizations had no official guidelines that direct the minimum requirements in the content and strategies of OVC support programmes. Agreed upon guidelines would help to ameliorate problems in providing efficient and effective support to OVC.

In general the findings of this study support the results from other studies as discussed in the literature review. However, a surprising result is the optimism and even joy some of the children seem to find in their daily activities. A further contribution of this study is the exploration of the relationships between siblings – an area that needs further attention.

In sum, the study gives a clear indication of the need for programmes that support the psychosocial and material need of those directly affected by the impact of HIV/AIDS in Ethiopia, such as the child household heads and their siblings who took part in the study.

6.1.5 Developmental theory and child household heads

Before I conclude, it is important to consider Erikson's theory of adolescence. This theory was developed in a context where it was assumed that children had parents. It is clear from this study that child household heads in impoverished circumstances are forced to take on parenting responsibilities at a much younger age than expected in theories of development. Yet, if the positive outcomes of Erikson's theory are considered the theory does seem to have some application. Erikson (1968:128-135) indicated that a successful outcome of this stage of adolescence is 'to reach a higher level of moral development, to tackle complex and critical existing philosophical systems and to define a new identity'. When reflecting on the lives of the child household heads it is clear that they have indeed undergone a process of moral development (placing the needs of siblings ahead of their own) in a complex world (where traditional support structures collapse when dealing with an illness heavy with stigma) and they developed a new identity of being a responsible caretaker (almost a parent).

The reflections of the children in the study may also provide some insight as to the negative outcomes of the developmental stage of adolescence as described by Erikson – *'negative identity'*, *'intimacy'*, *'time perspective'* and *'industry'*. In fact, none of the children developed a *'negative identity'* – such as taking on the role of a delinquent or a drug abuser – although a few had such tendencies by not wanting to be identified with the parenting role. However, cases pertaining to such behaviours as *'time perspective'* and *'industry'* are apparent. For example, because the children accepted adult role as permanent – *'time perspective'* – they avoid making plans for their own future. In other cases, many children attained the correct level of *'industry'* bearing in mind that their circumstances push them towards extreme level of activity or compulsively overwork. As household income dwindled with the parents' illness and death, all of the household heads in this study stopped attending school and worked very hard, for they have been committed to care for siblings in the household, manage the house and discipline their siblings.

Yet, an abrupt transition into adulthood as is some African contexts are not applicable although the deaths of parents bring this transition about to the children in the study. When reflecting on the lives of the child household heads it seems to be clear that socialization, as argued by Benedict (quoted in Sprinthall and Collins 1998:15-17), is not *'discontinuous'* since they have undergone a different set of adult roles – such as early entry into economic activities and household management.

To conclude, it became evident that all the children in the study have faced all forms of poverty. In these difficult circumstances, child household heads particularity need both material and psychosocial support in terms of:

- Parenting skills
- Household management
- Counselling
- Economic security

These households require immediate material assistance. Consequently, the community also has a particular role to play to unite and provide social assistance to child household heads. Community social welfare systems can link child household heads to larger support structures.

6.2 Recommendations

For the child household heads, severe economic insecurity is a dire situation that needs to be addressed urgently. These households are in desperate need of immediate material assistance in the form of handouts. Communities, NGOs and religious institutions need to develop distribution systems, including the identification of the households, which will provide these children with clothing, food, health services and education.

Most importantly, NGOs need to develop clear strategies that independently address the practical and strategic needs of these households. Also, special emphasis should be placed on the vocational skill training programmes. These programmes should be designed by taking both the demands of the market and the choice of the child household heads into account.

The legal and civil rights groups such as the Ethiopian Human Rights Commission, Institution of Ombudsman, and the Ethiopian Women's Lawyers Association can take part in implementing the legal protection of child headed households by giving them free legal support services and by investigating complaints free of charge.

Government policy makers also need to design a special social protection policy that reinforces intervention programmes/projects to specifically focus on the empowerment of child headed households couched within a human rights framework and creates access to the government's low-cost housing and priority to employment opportunity in the government sectors.

Comparative in-depth analysis on orphan children living in extended families and siblings living in child household heads may also give us insight in understanding the support from extended families and communities such as neighbours, churches and schools.

There is also a need for further studies on the circumstances of child household heads including areas covered by this study, namely: coping strategies of child household heads and relationships between siblings.

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Addendum A: Interview Guide

I. Interview guide for Life Story Collection

Introduction

Good morning/good afternoon. My name is M J Woldeyohannes. I am a student at University of South Africa (UNISA). The objective of this study is to explore the situation of child headed households affected by HIV/AIDS in Ethiopia. As part of my study, I am coming to discuss the situation with you. I will use the information I obtain from you to provide a clear picture of the roles and challenges of household care giving in child headed households affected by HIV/AIDS in Ethiopia especially to policy makers and service providers. Your presence and participation in this research is imperative to learn and understand the situation. The information I am going to collect will not identify you in any way and you may withdraw from the interview at any time without any negative consequences to you.

1. Tell me about yourself from birth based on both what you know and what your parents and others told you.
2. Tell me about what you know about your parents' place of birth, childhood, education, social life, behaviour…
3. Looking back on your life, what were the main roles that your parents played in your life?
4. Were you aware of the health condition (HIV status) of your parents before their death? Were you prepared for your parents' death? If yes, in what way?
5. Can you tell me the feelings that you had when your parents have died?
6. Why did you assume responsibility for the household?
7. Tell me about the relationship you have with your younger siblings by comparing the relationship before and after the death of your parents.
8. To what extent do your younger siblings assist you in providing livelihood for the household and managing it?

9. What changes did you notice in your life and in the household after the death of your parents? If there are changes, what are your reflections on them?
10. Can you tell me how it feels to take the role of a caretaker at this age of yours?
11. To whom do you turn to when you need support?
12. What are your future aspirations for yourself and for your younger siblings?

II. Focus Group Discussion Guide with Younger Siblings

Introduction

Good morning/good afternoon. My name is M J Woldeyohannes. I am a student at University of South Africa (UNISA). The objective of this study is to explore the situation of child headed households affected by HIV/AIDS in Ethiopia. As part of my study, I am coming to discuss the situation with you. I would use the information we generate to provide a clear picture of the roles and challenges of household care giving in child headed households affected by HIV/AIDS in Ethiopia especially to policy makers and service providers. Your presence and participation in this research is therefore imperative to learn and understand the situation. The information I am going to collect will not identify you in any way and you may withdraw from the interview at any time without any negative consequences to you.

Possible discussion questions

1. Because you are an orphan child, have you ever been given any unwelcome naming by people in your community? If yes, let us share the term/s.
2. How many households do you know in your community that exist without living parents (both mothers and fathers) and one living parent (either a father or a mother)? Do you have any idea or are you aware of the factors for these households to exist?
3. What are the major problems that you are facing in your homes and your main perceived needs?
4. What are the major problems you are confronted with in your day to day activities? How were/are life going on before/after the death of your parents? How do you perceive the role of your brother/sister as a child headed household in your home?
5. Do you want to add something before we conclude and close our session?

III. Interview Guide with Key informants

Introduction – statements stated in section I and II above will be used as an introductory opening.

Consent

I'm going to ask you some questions related to child headed households affected by HIV/AIDS, which some people might find difficult to answer. Your responses are vital to make this study reliable and concrete. Your answers are completely confidential. Your name will not be written on this study. Your honest answers to these questions will help me better understand the roles and challenges of child headed households affected by HIV/AIDS in household care giving activities.

_____ Agreed

_____ Not agreed

1. What are the major problems that OVC in general and child headed households in particular are facing and their main perceived needs?
2. What programmes does your office have in place to support this group? (Explore for the type and location of programmes, categories of children, age range of beneficiaries, and criteria for selection).
3. What are the major problems you are confronting in caring for OVC and child headed households? What are the different mechanisms you used to address these problems?
4. How do you perceive or evaluate support to this group in the community? And how will it be addressed to the best interest of this group?
5. What are the limitations of the support mechanisms? Explore how limitations can be addressed (i.e., adequacy, coverage, and sustainability).
6. What problems have you confronted in providing the agreed services to the identified target groups?
7. What do you recommend to improve the existing intervention?
8. Do you want to add some thing before we conclude and close our session?

Addendum B

Informed Consent of Guardians/Care Takers of Respondents

I have been informed and understand the personal and professional risks involved for the child whom I should take care of by participating in this study. On behalf of the child, I agree to assume those risks, and his/her participation is purely voluntary, without any promise of special rewards as a result of his/her participation.

Signature_____

Name_____ Date_____