



ISSN 2278 – 0211 (Online)

## Coping Strategies of Child-Headed Households in Bindura Urban of Zimbabwe

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### **Abstract:**

*An in-depth study of coping strategies of child-headed households was carried out in Bindura Urban of Zimbabwe. In-depth interviews and the survey method were used to examine the daily lives and coping methods of child-headed households. Data were gathered from child-headed households, community care givers, social workers and members of the community. The research identified a number of causes and challenges that were being faced by household heads. A number of coping mechanisms both positive and negative were employed by household heads in response to the challenges they were facing. The challenges included role adjustment, emotional and social distress, and sexual exploitation, lack of education and schooling and lack of adult care and support. The coping mechanisms identified included selling of family property, assistance from children's organizations, community members and dropping from school early. The research concludes that the challenges identified by household heads were essentially basic material needs. The formation of child-headed households is unavoidable and should be supported with appropriate support where possible. The study demonstrated that households were receiving regular visits and small amounts of material support from the extended family. It recommends that HIV and AIDS patients should receive adequate treatment, need for investment in financial and human resources and legal recognition of child-headed households.*

**Keywords:** child-headed households, coping strategies, households, role adjustment, HIV and AIDS

### **1. Introduction**

Child headed household is a new phenomenon in many societies, mainly because in the past there were institutions like the extended family that took care of the orphaned children. The child headed family is defined as a family that is led by a child who is below the age of 18 years and who has assumed parental responsibilities. These households more often than not lack the capacity to adequately provide for the children forming part of the household; children living in child-headed households are extremely vulnerable to abuse as well as to economic and sexual exploitation (Progress for children, 2009). It is estimated that more than 80% of all child-headed households are located in Sub-Saharan Africa (Mbugua, 2007). A parent may be present in the home but unable to assume any responsibilities due to illness, disability, and so on (International HIV/AIDS Alliance-Family Health International, 2005). A child has the right to be raised in a manner which provides him with the best possible development of his personality. There is a global consensus that this upbringing is (in principle) the primary responsibility of the child's parents.

This phenomenon was first noted in the Reikai district in Uganda in the late 1980s. Before this period, it was assumed that there was nothing called child-headed households (Foster and Mafuka, 1992). Scant research has been carried out into the causes, extent, nature and circumstances of this phenomenon (Meintjes, 2010). When information is available, it is often based on small-scale research projects and on anecdotal evidence (Bequele, 2006). It was generally assumed that orphaned children would be easily looked after within the extended family structures. The structures act as the social security system, protecting the vulnerable members of the community, giving care for the poor and the sick, and transmitting the traditional values. Due to the advent of HIV and AIDS scourge, child headed families is fast becoming a reality and a permanent feature of society. Relatives and neighbours used to provide safety nets for the vulnerable groups by providing care, but since the beginning of the twenty first century, the breakdown of those social networks expose the children to the vagrants of the harsh socio-economic and political environment. In the past three decades, the safety nets structured around kinship relations have undergone significant changes as a result of the growing number of terminally ill adults and orphaned children in countries with high HIV/AIDS prevalence. In Zimbabwe, recent estimations have shown how the availability of caregivers for orphans (grandparents, aunts, uncles and older siblings) will be significantly reduced in the near future

(Zagheni, 2010). Globally, figures have shown that more than 15 million children under the age of 15 lost one or both parents, and the figure was estimated to reach 25 million by 2010, with the majority of them being in the Sub-Saharan Africa (Gregson, 1994).

The concepts of 'coping' and 'coping strategies' are rooted in responses to the famines of the 1970s and 1980s in Africa (De Waal, 1989; Devereux, 1993). With the onset of HIV/AIDS, the language of 'coping' has become widely used to indicate the extent to which households and communities have the wherewithal to respond to adversities resulting from the epidemic (UNAIDS, 1999). However, notions of 'coping' can under-estimate the stark realities for many households and communities affected by HIV/AIDS, who are in fact 'struggling', rather than coping in any positive sense (Rugalema, 2000). In addition, the assumption of 'coping' may divert policymakers from the enormity of the emergency that a household or community is facing. Rather than devising a planned sequence of measures, or 'coping strategy', in response to the difficulties faced, households affected by HIV/AIDS often respond to immediate problems in a reactive way, for example by selling off assets to meet their immediate needs (Donahue, 1998).

In a child-headed household, the eldest child takes over the majority of responsibilities of the main caregiver. The emergence of this type of household in sub-Saharan Africa has been caused by the considerable increase of children in need of alternative care in conjunction with the insufficiency of alternative care options made available by governments. Consequently, the number of orphaned and vulnerable children resulting from HIV/AIDS is increasing. According to Shetty and Powell (2003), the orphan crisis caused by the HIV/AIDS pandemic is a serious issue globally and has immediate and long term social consequences. Sub-Saharan Africa is the most severely affected, accounting for more than 80% of those orphaned by HIV/AIDS worldwide (Shetty and Powell, 2003). African parents are often faced with challenges like political turmoil, ill health, divorce, migration, economic constraints and even death such that many are unable to care for their children. In the midst of these challenges, many families develop alternative living arrangements as ways of coping. The emergence of child-headed households is one such alternative. Others, however, are concerned about the vulnerability of young people caring for themselves about the costs to their safety, education, social development and health.

The HIV and AIDS pandemic has led to a decrease in the proportion of adult population (Gregson, 1994; Foster, 1995). As a result, this causes a change in care-giving arrangements where children at tender ages (less than 10 years old) are taking adult responsibilities. HIV/AIDS generates various types of households such as female headed, grandparent headed; child headed, and dissolved households. Coping is therefore about the ways in which we all recognize that our normal expectations of how life is and ought to be is adjusted when we realize that 'normality' has, for whatever reasons, switched to 'abnormality'. In recognizing that such a transition has occurred, we search for explanations of the new circumstances in which we find ourselves; we adjust our expectations and we search for courses of action that will enable us to achieve whatever goals are culturally significant for us. These processes require us to develop not only practical strategies for coping, but language and concepts to deal with the new situation (Demele, 2004). The emergence of Child-Headed Households in Zimbabwe is considered as one of several indicators of the weakening of the traditional safety nets. Since the publication of the seminal works of Foster (1995; 1997), the predominant idea is that these type of households are primarily a result of the increasing adult mortality, mainly due to HIV/AIDS. The existence of households headed by children is usually considered a particularly vulnerable situation as children who lack the necessary experience and skills to support a household and meet the basic needs of their siblings are left on their own. What remain undocumented is the levels of sustainability of the livelihood strategies they are engaged in for survival. The study seeks to examine the sustainability of some of the livelihood strategies adopted by Child-headed households.

The study shows how the livelihood strategies engaged by child-headed households are giving them a source of living. The study highlights the contributions of the livelihoods strategies to the lives of the children, and the problems that they encounter. The literature relating to how individuals and in particular children cope in response to the complex and difficult circumstances posed by HIV/AIDS usually in combination with other adversities is limited (Mann, 2000; FHI, 2003; Save the Children, 2002). For orphans, coping is observed at two levels in relation to meeting material needs and basic commodities and on an emotional level, part of what has come to be termed the 'psychosocial' aspects of responding to illness and death (Stein, 2003). These aspects clearly assist in identifying how the households manage their lives in the socio-economic context. The information may help stakeholders that support child headed households. Government, non-governmental organizations, and communities could find this information useful, in trying to improve intervention initiatives.

## **2. The Emergence of Child-Headed Households**

The HIV/AIDS pandemic is directly responsible for the emergence of a relatively new sociological phenomenon, the household in which there is no adult member and where by unspoken consent the oldest child assumes economic and "quasi parenting" responsibility for the siblings (Kelly, 2003: 61). In Africa where the epidemic is at its worst, a generation of children is growing up without their parents. The middle generation succumbs to HIV/AIDS, leaving the first and third generations to fend for themselves (Guest, 2001; Howard, 2003). The loss of one or more parents, forces children without any experience, education or resources heading and managing households, raising their younger siblings and attempting to be economically viable (Shetty and Powell, 2003). Thus the impact of HIV/AIDS does not end with the death of the sufferer but continues through the lives of the children who are orphaned (Guest, 2001). These orphaned children then attempt to restore balance and harmony within the four domains of family life as conceptualised by the resiliency model of family stress, adjustment and adaptation.

Evidence from various parts of southern Africa suggest that decisions to leave children living in child headed households are often made by relatives who are reluctant to foster older children, when there is a lack of contact between children and their relatives and when there is a death or illness of a potential relative caregiver (Foster, 1997; Foster and Williamson, 2000). The decision to leave these children in child headed households is made when adolescent siblings or older children have experience in child care, when

siblings wish to stay together and/or when it is the dying mother's wish for her family to remain intact (Foster, 1997; Foster and Williamson, 2000).

### *2.1. Causes of Child-Headedness*

The concept of child-headed households is a fairly new concept, but it is fast imposing itself as a permanent feature in our society, mainly due to the devastating effects of HIV and AIDS. Orphans in Africa rose from a mere 2% before the HIV and AIDS pandemic to 7% (UNICEF, 2000). According to Ali (1999), more than 50,000 children were orphaned by AIDS; this figure was estimated to reach a 1.2 million by 2005. There are various factors that can lead to orphanage and child-headedness. Prior to the advent of HIV and AIDS pandemic, natural deaths was the major cause of orphanage, and the figures were as low as only 2% in Africa. However, now due the devastating effects of HIV and AIDS the figures have risen to 7% (UNICEF, 2000). This scourge has caused untold suffering and distress among children under these conditions as they are forced to take nursing responsibilities and other household chores at a very tender age. As chronic illness continues it drives family members to sell assets in search of funds to pay medical bills, further aggravating their conditions, and sometimes leaving them with virtually nothing by the time they die (UNICEF, 1998). In Zimbabwe there has been an unprecedented increase in the number of children orphaned by HIV and AIDS. According to UNICEF's 2005 figures, there were 50,000 cases of child-headed households in Zimbabwe; three years later the figure had skyrocketed to 318,000, representing 3% of the households (IRIN, 2005).

The influence of westernization had led to gradual weakening of extended family ties, leading to a breakdown of traditional forms of authority which kept marriages intact and this has led to increased divorce cases, which in turn resulted in abandonment and eventual destitution of children (Bourdillan, 2000). Children are abandoned into grandparents' custody whose frail health conditions can no longer allow them to do anything leaving children to do all household duties. There is a general feeling that marriage had lost its traditional values and this has contributed to high divorce rate. High divorce rate among young people entering into marriages at early ages usually without adequate preparations is a cause of concern, (Bourdillan, 2000). Children are taking parental responsibilities of heading the family at very tender ages. In the African traditional societies, the extended family networks acted as social safety nets for orphaned children, where aunts and uncles took them into their families and provided care and guidance (Bourdillan, 2000). Evidence from Zimbabwe indicates that while most orphans in Child headed households do have extended family members who offer them help, some children prefer to live alone for fear of losing household property after inheritance and also that some relatives prefer not to take children in but rather prefer to offer support to the orphans who continue to live at their parents' home (UNICEF, 2001; Germann, 2005).

The child heads interviewed in Mhondoro district of Zimbabwe in a study suggested that ill-treatment or potential ill-treatment by relatives is a major factor contributing to their decisions to establish their own Child headed household. The relationship between the children in Child headed households and their temporary guardians immediately after the death of their parents, the nature of the ill-treatment and the reaction of the children and some relatives to mistreatment of orphans force children to move out (Chizororo, 2006). In Lesotho children are "incorporated into households as workers" (Young and Ansell, 2003:470). Being overworked denies the orphans freedom and opportunities to "play" with other children in the village notwithstanding the physical strain and exhaustion the orphan's experience. Although the orphans reported that they do not necessarily remain passive in the face of ill treatment, their reaction to differential treatment is often met by harsh words that have long term psychological impact on them.

Migration significantly influences the growth of child-headed households. Movements of relatives into towns, or into "the Diaspora", seeking better employment opportunities leave children alone assuming parental roles. According to UNICEF (2000), urban-bound migration results in reduction of contact between surviving relatives and the orphans. This is exacerbated by economic independence associated with urban life, which encourages the breakdown of extended family networks, thereby exposing the orphans to social and economic hardships. For those who move into "the Diasporas", it might take considerable time before they get employment; forcing children back home to assume parental roles, which may force them to adopt new livelihood strategies. . In countries affected by social unrest, as in the case of Rwanda, violent conflict led to the emergence of child-headed households (MacLellan, 2005; ACCORD, 2001).

### **3. Sources of Livelihoods for Child-Headed Households**

Child-headed households are engaged in various activities that form their livelihoods. These sources of livelihoods include; vending, joining food-for-work programs, and, in some cases, involving themselves in dangerous activities, such as prostitution. Those in the vending business were trading in an assortment of activities, which include selling of roasted maize, and fruits, such as oranges and bananas (Narayana, 2000). In the Philippines, child-headed households are involved in activities such vending, laundering, sewing, and other menial jobs. According to Todaro and Smith (2003), children and women are involved in various income-generating activities, including production of goods they will sell at village market places. Some of these goods are region-specific, but there are common activities that cut across the regional divide, including beer brewing, processing of food, and making of hand crafts and textiles.

Food-for-work programs are becoming permanent survival strategies among the disadvantaged groups of the rural society. In these programs, people (mainly children and women) can carry out some community development works and are paid in form of food handouts. Their work includes; construction and maintenance of infrastructure, such as roads, irrigation structures, and dams. According to UNICEF (1998), food-for-work programs had played a very important role in the developing world, where governments

are facing severe financial constraints. For example, in Bangladesh, the government found non-governmental organizations' role in food-for-work programs practical in poverty alleviation.

Vulnerable groups of the society are benefiting immensely from such programs through provision of basic nutritional requirements and, in some cases, where these programs are paid in cash; they have been very useful in affording them access to health and educational services. The informal sector is another form of livelihood child-headed households and female-headed households adopt as their livelihood. The informal activities include selling of fruits, food (cakes, sauces, soft drinks, and butter), household goods (such as soap), and traditional handcrafts. They are also involved in activities, such as poultry and livestock rearing (ISIS, 1983). Some child-headed households engage in risky activities, such as prostitution and gambling (Jackson, 1992). This practice is common among female-headed households. Jackson also indicated that this form of livelihood is the third largest source of livelihood after agriculture and beer brewing, among rural women and children.

#### **4. Stakeholders in Support of Child-Headed Households**

There are so many stakeholders that are involved in the provision of care to child-headed households, including; non-governmental organizations, government, and the community. Non-governmental organizations are providing services, such as health, education, and welfare services, and in some cases, psychosocial support. Some non-governmental organizations went one step further to provide these households with shelter and material support, especially to those affected by HIV and AIDS. They are also involved in assisting school-going children with school fees and providing supplementary food requirement. The community is also taking an important role in the support of child-headed households. They help in the provision of food, paying of school fees, and giving social support in an attempt to reduce the impacts of stigmatization associated with child-headed households, especially to those affected by HIV and AIDS. According to UNICEF (2004), the community had been very helpful to the cause of child-headed households. They had been involved in fundraising projects on behalf of households for educational, economic, and other social needs. The devastating effects of HIV and AIDS is that, in most cases, both parents will succumb to the illness, and members of the extended families, especially grandparents are left to take fostering responsibility of these orphans. In Uganda 24% of the children between the age of 5 and 15 are fostered by grandparents (Hunters, 2000).

However the extended family, as an institution, had of late been under assault from various quarters thereby weakening it in the process. The family structure worldwide is changing in response to the global and local socio-economic conditions. There has been a general movement towards nuclear families; this movement seriously exposed child-headed households, which traditionally benefited from the social networks of extended families. There has also been an influx of orphaned children in society, thereby creating a security crisis of immense magnitude to the orphaned children. Families had been decimated by HIV and AIDS and are finding it difficult to accommodate orphaned children. Some children are taken into childcare institutions, owned mainly by churches, usually with the support of the government or non-governmental organizations. These institutions are being over-subscribed and their capacity, especially in heavily infected countries, can take only 1% of the orphans (Hunter, 2000).

There is a general observation that children in institutions lack the basic traditionally accepted social and cultural values in society. They have low levels of educational attainment and have problems adjusting to real life outside these, like that offered to children in a 'normal' family set up. Some children raised in institutions usually look down upon their own communities as being inferior because they are used to the trappings of usually westernized standards of care in these institutions (Powel, 2006).

#### **5. International Obligations**

##### *5.1. Declaration of the Rights of the Child (1959)*

In 1959, the UN General Assembly adopted the Declaration of the Rights of the Child containing a Preamble and ten Principles. The Preamble proclaims that every child should "have a happy childhood and enjoy for his own good and for the good of society the rights and freedoms herein set forth, and calls upon parents, upon men and women as individuals, and upon voluntary organizations, local authorities and national Governments to recognise these rights and strive for their observance by legislative and other measures progressively taken". Despite the fact that this Declaration delved deeper than its predecessor and was an important step on the way to the global recognition of children's rights, it was still merely a statement of intent, incorporated in a declaration, a non-legally binding document. The right of a child to receive care by means of either biological or moral parenthood can be found in Principle 6 of the 1959 Declaration. It proclaims:

The child, for the full and harmonious development of his personality, needs love and understanding. He shall, wherever possible, grow up in the care and under the responsibility of his parents, and, in any case, in an atmosphere of affection and of moral and material security; a child of tender years shall not, save in exceptional circumstances, be separated from his mother. Society and the public authorities shall have the duty to extend particular care to children without a family and to those without adequate means of support. Payment of State and other assistance towards the maintenance of children of large families is desirable.

This Principle is aimed at the realisation of the 'full and harmonious development' of the personality of a child and confirms that a child should preferably grow up in the care of its parents. Should this not be attainable a situation that must be avoided as much as possible especially in the case of young children a child should in any event be raised in a safe environment, both morally and materially. Included in this Principle is the responsibility of society and of the public authorities for the care of children without parental care. These children should also be allowed to grow up in "an atmosphere of affection and of moral and material security" (Veerman, 1992).

### 5.2. *Convention on the Rights of the Child (1989)*

Although the 1959 Declaration figured prominently in the promotion and global recognition of children's rights, there was a growing realisation that a legally binding instrument was lacking. In 1978, the year preceding the International Year of the Child, the government of Poland proposed to convert the 1959 Declaration into a legally binding Convention on children's rights. The proposal as such was rejected, but the idea to convert the 1959 Declaration into a Convention was in fact accepted and referred to the UN Commission on Human Rights; the Commission decided that a proposal for a Convention, based on the 1959 Declaration, should be drawn up (Detrick, 1999).

The Convention is a unique document in that it encompasses civil and political rights as well as economical, social and cultural rights. It expresses the evolution of the views on children's rights and the changed attitude towards children, whereby they are no longer viewed as miniature adults, but as human beings who have the right to grow into balanced and responsible adults. The child is seen as the owner of rights as well as being the subject of rights (Meukese, Blaak and Kaandorp, 2005). The Convention is regarded as a treaty in which the international progression of human rights and children's rights are brought together (Kaime, 2010). It is acknowledged as the most important international treaty, concerning all aspects of children's rights (Sloth-Nelsen, 2004). Whether civil, political, economic, social or cultural, all rights must be regarded as justifiable and States should ensure procedures for non-compliance with these rights to be redressed and effective remedies for violations thereof should be established (UN General Comments, 2003).

The Convention is acknowledged as "a transnational, multicultural, cross-cultural and ultimately local framework" for children's rights (Kaime, 2010). With the adoption of the Convention – containing universal, legally binding standards – children's rights were put firmly on the map, resulting in global attention for children and their rights. Consequently, States Parties changed national laws in accordance with the Convention, children's acts were constituted, children's ombudspersons were appointed and a host of other measures taken to ensure those children's rights were observed. For the first time in history, States could be held accountable for the manner in which children were treated and for violation of children's rights (Newell, 2005).

The Convention calls for children to be protected, for the prevention of harm, the provision of assistance ensuring basic needs and it advocates the participation of children in matters that concern them. These aims are also known as the four P's (protection, prevention, provision and participation) (Sloth-Nielsen, 2004). Another frequently used and comparable categorisation is the division of rights into three main types: provision, protection and participation ("3 P's") (Quennerstedt, 2010). It is argued though that children's rights should be graded as civil, political and social rights, unifying children's rights with – rather than detaching them from – other human rights (Quennerstedt, 2010). It lies beyond the scope of this study to elaborate on this discussion and thus references are made to both classifications.

### 5.3. *Guidelines for the Alternative Care of Children (2009)*

In December 2009, the Guidelines for the Alternative Care of Children, aimed at the enhancement of (inter)national legislation with regard to alternative care of children, were welcomed by the UN General Assembly with a recommendation to all Member States to take them into account. Paragraph 37 of the UN Guidelines pays special attention to child-headed households. It recommends that States ensure that these households "benefit from mandatory protection from all forms of exploitation and abuse through the appointment of a legal guardian, a recognized responsible adult or, where appropriate, a public body legally mandated to act as guardian". This amounts to a de facto acceptance of child-headed households as a form of alternative care. In recent years coinciding with the drafting period of the UN Guidelines a number of African countries have revised national legislation to accommodate acceptance and regulation of child-headed households; this endorsement of child-headed households as a form of alternative care raises many questions, principal amongst which the issues of protection of children belonging to such households and in particular of the child acting as head of the household. The best interests of the child principle should be taken into consideration in all actions concerning children. Although the application of this principle remains open to debate, it seems improbable that it is in children's best interests to grow up in a child-headed household, both for children heading a family as well as for the other children belonging to the household (UN General Assembly, 2010).

## 6. **Research Design and Methodology**

A local community survey was developed. The purpose of the survey was to provide an additional means to gather data on coping strategies of child-headed households. It was used as an additional tool in conjunction with interviews. The community survey also provided a useful comparison of responses in relation to discussions. The survey was designed to be brief and accessible in terms of language and literacy levels. The method was also used due to its feasibility and relatively economic nature in the collection of data. The sample involved heads of households, representatives of Non-Governmental Organizations (NGOs) and Community Care Givers drawn from Bindura urban.

Documentary search was used in the study. The contemporary and historical frameworks that documentary search produced allowed for parallels to be drawn and trends to be identified. Information from the Department of Social Welfare, NGOs and Community Care Givers pertaining to the coping strategies in Bindura urban was solicited. NGOs such as SOS, Red Cross and United Nations Children's Emergency Fund (UNICEF) among other organizations will be used to get compiled reports on workshops and seminars on child headed households and their coping strategies. Documentary search consisted of archival material and existing documents such as material from conference proceedings, magazines, journals and text books. The research viewed these documents on child headed households as critical in providing current information.

## 7. Challenges Faced By Child-Headed Households

The economic impact of HIV/AIDS on families and children generally comprised three consecutive stages: the period of sickness, the time of death and the period following death. During the first phase the household was confronted with direct costs – mainly for medical treatment – and indirect costs through decline and eventually loss of household income, both of the chronically ill and of other household members who had no choice but to divert time from generating income to providing care. At the time of death, there were often substantial funeral expenses. During the final stage, additional indirect costs were incurred through loss or dispossession of household assets and repayment of loans taken out to cover medical and funeral expenses. In most cases, households were impoverished beyond the stage of recovery.

### 7.1. Role Adjustment

All the ten respondents indicated that they had to make adjustments from being children to being heads of households following the death of their parents. They indicated that the adjustment carried many challenges. Nkomo (2006) in his study in Gauteng and Kwazulu-Natal identified several key components of this adjustment. These included the feeling of having lost one's childhood and sense of self with the attendant feelings of deprivation; of responsibility towards one's family (younger siblings) and the obligation to take the place of the deceased parents; of being abandoned by extended family members who supposed to take the responsibility of looking after them; of concern for surviving in the face of economic hardship; of grappling with multiple and competing responsibilities; and of helplessness and uncertainty about personal safety, family disintegration and discipline.

In a study by Mkhize (2006) in Kwazulu-Natal highlighted the multiplicity of adult roles that the heads of child-headed households undertook, notably decision making, leadership, economic provision, care giving, conflict management and housekeeping. Children in this study reported that it was stressful to carry the roles; for example one 16 year old child head from Chipadze suburb said he found it difficult to advise his siblings who were almost his age especially when they abscond from school or came home late. At times the siblings fight amongst themselves and he must resolve conflicts amicably and most of the time he was neither sure nor experienced to know where to start from since it was always his parent's role. A study of child-headed households in India similarly reported that the adjustment of children into the household head role was very challenging (India HIV/AIDS Alliance and Tata Institute of Social Science, 2006).

### 7.2. Emotional and Social Distress

Being a head of the household is associated with psychological and emotional trauma, as well as social distress. Six of the respondents who had lost their parents due to HIV and AIDS related illnesses indicated that they were being exposed to on-going traumatic stress. Community care givers indicated that failure to support children to overcome such trauma did not only jeopardise their personal development. In a study in Kwazulu-Natal, South Africa it explored the life narratives of children in child-headed households compared with adult-headed households (Donald and Clacherty, 2005). They found that while most (92%) of the events mentioned by children from child-headed households were negative, only 55% of events mentioned by children from adult-headed households were negative. Furthermore, all child-headed households reported experiencing the death of at least three close relatives, compared with only a couple of the children from adult-headed households. Many of those children seemed not to have dealt with their grief and loss. The health status of children living in child-headed households in six of the respondents was abominable. Their poor status prevented them from accessing medical care systems. A number of specific healthcare problems were being encountered by children. These included psychological trauma as a result of parental loss during childhood. Such trauma was also increased by the rejection by extended family members or the community, as well as frequently experienced social stigma. House hold heads indicated that they were not emotionally capable of coping with their role of primary caregiver, which led to further psychological problems. Compared to other children belonging to the household, the household heads experienced a higher level of psychological and emotional strain. One study suggested that when siblings were able to stay together, even while living in a child-headed household, their psychosocial and emotional wellbeing was no worse than that of children who were separated and lived with different families (Germann, 2005). Similarly findings from the study carried out all ten respondents had been living with their siblings together and they found comfort in facing any life challenges being together as they could not stand rejection or abuse by the extended family or community.

### 7.3. Sexual Exploitation

Sexual abuse of children takes place in all demographic groups, not only among child headed households. However, it was more frequent among “children living without one or both of their biological parents, children whose primary care giver was absent or unavailable,[and] children placed in the care of more distant or unrelated persons” (Mullen and Fleming cited in Mabala, 2006: 416). Children in child-headed households were vulnerable to sexual exploitation in the form of sex in exchange for favours, such as food. Community care givers indicated that they regularly urged orphans to report cases of sexual abuse to them. All the respondents indicated that they had not faced any form of sexual abuse.

Girls, in particular, were vulnerable to sexual exploitation. UNAIDS statistics showed that while African girls (aged 15-24) were no more (and probably less) sexually active than boys, they were about two and a half times more likely to have acquired HIV (Mabala, 2006). In South Africa, specifically, 21-31% of girls in this age range had HIV in 2002, compared with just 9-13% of boys. Hundreds and millions of girls and young women living in the path of HIV have had no or limited benefit from schooling, feel unsafe in their communities, facing significant risk of sexual coercion and – having few or no assets or livelihood prospects had been compelled to exchange sex (inside and outside of marriage) for money, gifts, food and shelter (Mabala, 2006).

#### 7.4. Educational and Schooling

Household heads indicated that they had to look for menial jobs such as vending and working in nearby farms in order to get money for school fees even before they were orphaned. They indicated that some of their siblings had dropped out of school even before orphaned. Education is one of the facets of the life of a child that was threatened by HIV and AIDS and by child-headed households in particular (Goldstein, Anderson, Usdin, and Japhet, 2001). When a parent is dying or has died of AIDS, social stigma acted as an additional stumbling block to the continued education of the children (Ayieko, 1997; Masondo, 2006; Robson and Kanyanta, 2007), some of whom report being bullied and harassed (Robson and Kanyanta, 2007). Household heads were particularly vulnerable to dropping out of school in order to care for their younger siblings who continued with their education (Masondo, 2006).

Child headed households often could not afford to continue schooling and have to spend their days eking out survival (Ayieko, 1997; Kakooza and Kimuna, 2005; Richter, 2004). The cost of schooling was not restricted to school fees but also to learning materials such as textbooks and stationary and school uniforms (Yamba, 2006). Robson and Kanyanta (2007: 419) observed that "Child-headed households were often extremely vulnerable and impoverished, drove children into work and prevented them from attending school." Other reasons cited by respondents for dropping out of school included economic stresses on households, changes in family structure, new responsibilities to care for the sick, the elderly or siblings and the lost parental guidance. A study in Zimbabwe by Walker in 2002 found that 40% of school age children in child-headed households were not attending school (Walker, 2002).

#### 7.5. Lack of Adult Care and Support

Apart from the difficulties discussed above, child headed households indicated that they were being confronted with a number of other specific challenges. They indicated that one of the dangers was failure to rely on daily adult care support and protection. Household heads indicated that while they were responsible for supplying the household with material and emotional support, they were both physically and mentally immature and not adequately equipped for the role of principal caregiver. Community care givers were of the view that those children were exposed to high risk of neglect, violence, sexual assault and other abuses and were frequently living in permanent fear due to the fact that they had to fend for themselves.

A household without an adult caregiver did not provide children with the chance to learn the skills essential to their development. The natural bond between a child and its parents or main caregivers forms during early childhood. This bond is believed to provide the foundation for relationships in later life. The relationship between a child and his parents remains of the utmost importance in children's lives. Parents provide a secure zone in which children feel protected. In general, children learn ways of coping with stress and anxiety from their parents, parental behaviour in times of stress forming an example. Children model themselves on their parents in other behaviour as well, either by precept (a child is told by his parents what he should and should not do) or by percept (a child observes and copies his parents' behaviour). Parents teach their children moral standards, encourage positive behaviour and discourage unwanted behaviour displayed by a child (Rutter, 1982). It may therefore be concluded that children in child-headed households were severely disadvantaged in that they did not have the opportunity to learn much-needed life skills.

Children living in child-headed households are considered to be the most vulnerable of society because their fundamental rights and freedoms are usually structurally violated. These children were usually confronted with more difficulties than other vulnerable groups who were formally or informally cared for, since they could not rely on adult protection and support. Other problems encountered were the inaccessibility of social benefits and the loss of possessions to property grabbers. The household head almost certainly lost rights as a child when taking on the responsibilities of caring for the family. Furthermore, growing up without parental care and adult role models might lead to irresponsible behaviour and related behavioural problems (Maclellan, 2005). Adult care and love, security and a sense of belonging are the main psychosocial needs of children (Borris, 2008).

Research carried out in Uganda found that time for play and leisure was non-existent or very limited for children in child-headed households, as most children had to work to survive. Children not receiving help and care from extended family or members of the community did not understand why their needs were being ignored; they felt misunderstood with regard to their situation as well as unwanted. Lack of understanding, acceptance and respect for children living in a child-headed household by the community had a negative influence on the material and psychosocial needs of these children (Dalen, Nakitende and Musisi, 2009). Respondents highlighted challenges of getting money for rentals and those owning houses could not pay rates, electricity and water since the bill would have begun accumulating from the period when the parent was sick.

### 8. Coping Strategies of Child-Headed Households

#### 8.1 Selling Family Property

Household heads indicated that in some cases they had to resort to selling of household property such as radios, televisions and fridges in order to get a source of income. Gow and Desmond (2002) noted that there was evidence from Tanzania and Uganda that suggests radio ownership increased in households with no deaths and decreased in households that experienced death. Once households sold their assets and used their savings, the chances of them recovering and rebuilding their livelihoods became difficult.

#### 8.2 Assistance from Childcare Organisations

Three of the household heads indicated that their siblings who were below five years were taken into childcare institutions such as SOS Children's Village. These institutions are being over-subscribed and their capacity, especially in heavily infected countries, can take only 1% of the orphans (Hunter, 2000). There is a general observation that children in institutions lack the basic traditionally

accepted social and cultural values in society. They have low levels of educational attainment and have problems adjusting to real life outside these, like that offered to children in a 'normal' family set up. Some children raised in institutions usually looked down upon their own communities as being inferior because they were used to the trappings of usually westernized standards of care in institutions (Powel, 2006).

### *8.3 Assistance from the Community*

The other coping mechanism was receiving help from relatives and neighbours which was an important support to the efforts of households facing an adult death. The community was also taking an important role in the support of child-headed households. Household heads indicated that they sometimes received assistance in cash or kind from other households. Most heads who were interviewed highlighted that neighbours often assisted in the form of basic food stuffs like mealie-meal and cooking oil. One respondent indicated that his neighbour once bought his younger brother two pairs of uniform and had always relied on his neighbour whom he felt understood his situation. However, this was only possible if the other households were relatively better off. They received help in the provision of food, payment of school fees, and social support. Community care givers indicated that was an attempt to reduce the impacts of stigmatisation associated with child-headed households, especially to those affected by HIV and AIDS. According to UNICEF (2004), the community had been very helpful to the cause of child-headed households. UNICEF had been involved in fundraising projects on behalf of households for educational, economic, and other social needs.

The devastating effects of HIV and AIDS was that, in most cases, both parents succumbed to the illness, and members of the extended families, especially grandparents were left to take fostering responsibility of these orphans. In Uganda 24% of the children between the age of 5 and 15 were fostered by grandparents (Hunters, 2000). However, the community care givers indicated that the extended family had been weakened due to economic hardships. The family structure worldwide was changing in response to the global and local socio-economic conditions. There had been a general movement towards nuclear families; this movement seriously exposed child-headed households, which traditionally benefited from the social networks of extended families. However respondents who had known relatives indicated their support through rare visits to see them but had not offered any financial support. The community care givers indicated that the level of support provided to child headed households by communities was commensurate with what was then available.

Three respondents indicated that the community was helpful by providing menial jobs like clearing people's yards, harvesting maize but the problem would then be payment which would not be done at all or the amount reduced from the previously agreed yet work had been completed. The children felt taken advantage of because there was no adult to represent them or simply because they were orphans. Community based organisations had assisted the households with payment of school fees and started income generating projects like poultry projects though four of the respondents could not take up the project because they had rented accommodation and landlords would not give them space. Those who were going to schools said it was not easy for them to keep the projects running and had since stopped because the projects had to be balanced with school work which would affect school in the end. Six respondents who owned accommodation offered a room to rent to individuals as a source of income and they were relying on the rentals as income base encountered a challenge with some lodgers who were difficult in paying rents on time.

The issue of sustainability of the livelihoods which were recorded from the interviews plays a pivotal role in earning the children a living through positive coping strategies. Most heads felt the jobs they engaged in were short term and seasonal therefore could not be relied on solely and also some jobs had small income like phone airtime vending which one respondent was doing during weekends and school holidays.

### *8.4 Dropping from School*

Leaving school early has increasingly been documented as a strategy adopted in order to relieve difficulties at home (UNICEF, 2003). Despite the evident emotional as well as learning benefits awarded through attending school, four household heads interviewed indicated that some of their siblings were not attending school. The lack of school fees or money for books and uniforms were some of the most commonly cited reasons for withdrawing from school. As one or both parents die, the capacity of households to remain intact will be difficult. As a result of this relatives and friends of the family took in individual children where the resources were available. Most commonly, grandparents, in particular, grandmothers seemed to take over this parenting role. There might be a situation where no able-bodied adult was available to provide resources and maintain households and families together. This led to the dissolution of the family unit as a household being either a child headed household.

A study conducted on 215 households in Zimbabwe revealed that about 40 percent of the sample households had taken in orphans who had lost both parents. 65 per cent of households where the deceased adult female used to live before her death were reported to be no longer in existence in both the urban and rural sites (Gow and Desmond, 2002). The worst impact of HIV/AIDS on households could not be seen because of the dissolution of some households, which were not possible to be counted. Economic hardship was described in every household visited throughout the research. Household heads and community care givers mentioned material difficulties relating to access to food, school fees, soap, blankets, bus fares, clothes and shoes. Household heads described difficulties in securing basic commodities and the impact of lack of these had on being unable to care for the household. A lack of food coupled with the absence of adults in the household to secure food meant that the burden fell on even very young children.

In many cases, household heads shouldered the burden of responsibility for providing enough for younger siblings. When parents died, support from other relatives such as paternal or maternal relatives provided some reprieve, although six household heads described how the support itself came to an end after the death of the relative or when the relative became unwell or had other



commitments to fulfil, such as assuming the care of other orphans within their families. Three household heads indicated that they had enough to eat and thought they were coping because they had received rents from tenants and some form of extended family support that was helping to sustain the household.

Household heads and community care givers identified other needs as well as access to food and commodities. Four household heads described the level of abuse and maltreatment that they had experienced from extended family members and some community members. They described episodes of physical, verbal and sexual abuse throughout the study. Three household heads described how, following the death of their parents, property which they should have inherited was taken by other extended family members.

While traditional community-based support networks enable reciprocal arrangements to alleviate hardship, these were increasingly struggling to respond adequately, given the scale of the epidemic (Family Health International, 2003) and were not always equitably applied (Baylies, 2002). Research has demonstrated that the poorer the household, the more likely it was that measures adopted would prevent longer-term recovery of the household economy (Skoufias, 2003). Eventually, many households reached a point where they had no further coping mechanisms to employ and were either dissolved or failed to ever regain the quality of livelihoods that they had prior to the death of a parent (Donahue, 1998; Seeley, 1993; Yamano, 2002).

### **9. Role of Community Volunteers and Care Givers**

A community care giver is a person who regularly voluntarily assist a household whose members are related or not related to him/her in doing household chores, offering advice, giving spiritual, psycho-social and material support. Questions on information regarding the community volunteers were aimed at establishing information about the welfare of the children in the community. All the community volunteers interviewed had an understanding of the situations of the child headed households in their community. The researcher also sought information pertaining the number of years of experience as community volunteers and the number of children they assist in the community.

Three community volunteers interviewed indicated that they had more than five years experience working as community volunteers and working with average of 10 and 15 children per volunteer. The children included orphans who were in the care of their relatives. The Community Volunteers have reasonable experiences to share about the situations of the child headed households in the community. The researcher asked the caregivers about the psychological wellbeing of the children and how they related with friends and peers and all the caregivers agreed that they believed the children's psychological wellbeing was not healthy. They were further asked about the dreams and aspirations of the children. Two of the care givers indicated that they had known the aspirations of the children, while one indicated that she had not discussed the issue. The questions were aimed at establishing whether or not the caregivers engaged with the children on personal issues that concerned them and were able to provide parental support towards supporting their emotional and psychosocial development. The care givers cited lacked emotional support and psychosocial issues as factors that affected the wellbeing of the children.

The care givers discussed concerns around information and education on health care, that education on reproductive health and HIV and AIDS was be beneficial to efforts that address the concerns of the child headed households. They noted that lack of education on reproductive health increased the vulnerability of children. Increasingly, child-headed households had become accepted as a form of alternative care and as a placement option for children in need of care. The question arose as to whether it was justifiable and legitimate to regard child-headed households as a novel alternative care mechanism to cope with the increasing number of children without parental care. In one study, child-headed households were posed as third in the line of preferred forms of alternative care, the order of preference being:

- Kinship care;
- Adoption and fostering;
- Community-supported child-headed households;
- Household type institutions; and
- Residential institutions.

### **10. Placement in Institutional Care**

Placement in institutional care was deemed expedient when a child could not be cared for in another setting as a result of unavailability of other forms of care or in case the child is unable to cope with other care situations. A child was not being placed in an institution unless this was in his best interests. With regard to the suitability of care institutions, Article 20 of the Convention on the Rights of the Child (CRC) does not provide any standards whatsoever. According to Article 3 paragraph 3 CRC, States must ensure that institutions adhere to "standards established by competent authorities", standards on issues of safety, health, the number and suitability of staff, as well as competent supervision. Further indicators as to the contents of these standards were not given and States were required to establish suitable benchmarks. Some countries already had minimum standards in place for certain forms of alternative care or had recently implemented them. However, without the requisite financial resources, trained staff and adequate monitoring mechanisms to ensure the quality of care, the provision of suitable institutional care was not feasible (SOS Children's Village International, 2010). The UN Guidelines provided that "use of residential care should be limited to cases where such a setting was specifically appropriate, necessary and constructive for the individual child concerned and in his/her best interests." Children who were raised in institutional care facilities tended to lack the experience and psychosocial skills needed to integrate into society on reaching adulthood. Additionally, children had experience learning difficulties, long-term or permanent developmental impairment and medical problems. The separation from parents and siblings had caused behavioural problems in children and their physical

condition had suffered while living in an institution due to the fact that they were sometimes left in a state of total inactivity for years, without adequate opportunities for mobility, resulting in the underdevelopment of muscles and spine. In some cases, privation of sufficient adult contact resulted in children resorting to self-harm. In addition, children were not able to build and rely on social connections; the lack of a social safety net led to an increased long term vulnerability (Williamson, 2004).

### **11. Kinship Care**

Care provided by closely related family members or, alternatively, by more distant relatives or close family friends, was known as kinship care or extended family care. Within the framework of this study both terms were used interchangeably. It was generally seen to be the most favourable alternative care environment for children, in most cases ensuring continuity in their upbringing and family values. However, kinship care was not necessarily suitable and appropriate in every situation. Due to the vast number of children in need of alternative care in sub-Saharan Africa, the extra burden was overstressing the extended family's capacity. As a result, kinship caregivers lacked the financial resources to provide sufficient care, siblings were separated, they had been treated differently from biological children belonging to the household and children's emotional needs were disregarded. The suitability of family members as carers was generally not assessed. In combination with the lack of a monitoring system, children found themselves in an inappropriate environment and subjected to abuse or exploitation. These children were more at risk of receiving corporal punishment from their kinship carers than the caregivers' biological children.

When children were absorbed by the extended family, the decision on where they would live and who would raise them was based on the willingness and capability of the extended family members, rather than derived from children's own wishes and based on their best interests. Another possible disadvantage was that children lost their inheritance to extended family members. The stigma associated with HIV/AIDS led to extended families abusing affected children.

A growing trend was discerned where orphans and other children in need of alternative care were being looked after by one or both of their grandparents, who had hitherto already played an active role in their upbringing; children generally valued care provided by a grandmother as the most preferred form of care. These households were also known as skip-generation households or granny-headed households. Depending on the age of the children and the health of the grandparents, the latter did not live long enough for children to reach adulthood while in their care. Consequently, children were confronted with another loss of their caregiver and were faced with yet another dramatic change in their care situation. Kinship care, whether temporary or long-term, was the most practised type of alternative care in sub-Saharan Africa and is also encountered in situations where biological parents were alive. One study indicated that living in a child-headed household was not easy, but being ill-treated by extended family members was worse, implying that kinship care automatically led to ill-treatment. The same study stated that children who had been living without an adult caregiver did not wish to be controlled by an adult carer again, which left them with no other option than to live in a child headed household.

### **12. Foster Care**

Across sub-Saharan Africa, the term 'foster care' was open to variable interpretation which differed from the definition provided by the UN Guidelines and the accepted use in the more industrialised countries (the legal placement of a child within a family other than its biological family (Williamson, 2004). In the latter, foster care was formal and in most cases temporary, carried out by non-family members. It included emergency care for babies, transitional care this was short-term care, provided by trained caregivers, during whom a suitable and permanent care facility was found and short term or medium-term care for children who were temporarily unable to remain in their own home situation. Foster care allowed the time and the space to improve the home situation after which children would be return to their parents.

The biological parents usually retained parental authority. In comparison to kinship care, the quality of care provided by unrelated foster caregivers was higher due to the fact that family members generally felt pressured to care for next of kin whereas unrelated carers did so voluntarily, out of a selfless motivation (Tolfree, 2009). Informal foster care was encountered in most countries on the African continent; it was often a permanent arrangement, provided by the extended family. Although this type of foster care was de facto kinship care, in a number of countries there was an important factor at play for kinship carers' preference to be classified as a foster parent. In some countries foster parents were eligible for grants or other forms of welfare; for instance, in order for a child to be eligible for a foster care grant often higher than other grants the caregiver was supposed to be identified as a foster parent. For the purpose of this study foster care provided informally by extended family members, was categorised as informal foster care. The situation where a child was formally fostered by a family member was referred to as formal foster care or formal kinship care (UNICEF, 2004).

### **13. Conclusions**

This study has highlighted the fact that many children face considerable vulnerability after the loss of a parent and the point at which they are considered to be orphans. The study revealed that in current times, children are more likely than ever to be expected to assume the responsibilities of care for sick relatives or younger siblings and of providing sources of income or food, rather than sharing these responsibilities with adults as part of a household unit. Young women in particular described burdens of caring practically and emotionally for terminally ill adults which most adults would find overwhelming. While on the surface they 'coped', the toll that it had on their mental health and well-being was evident in their often highly emotional responses to the research process. The research has illustrated the importance of engaging children more centrally in the process of identifying household and community needs and in responding appropriately.

This research has clearly shown the distinct and unique perspectives that children and young people affected by HIV and AIDS have on their lives and the importance of incorporating these views in HIV and AIDS programming. Many demonstrated considerable resourcefulness, but required further guidance and support in order to make their livelihoods more sustainable and to alleviate some of the burden of care put upon them. Household heads are in need of support since they have assumed responsibility for the care of others, often from a young age, but are not awarded the status or recognition as adults. The psychosocial impact of HIV and AIDS on children and their families demands much closer attention, and a greater understanding needs to be developed of their capacity to cope emotionally with grief and loss, and how best to respond to these needs. Adopting a more holistic understanding of children's capacity to cope on emotional as well as practical levels is vital if future programming is to respond more effectively to their needs and allow them to build resilience, enhance their resourcefulness and be able to live up to the huge expectations that are placed upon them.

The lack of an adult role model's presence in the household deprives children of the chance to acquire social skills which are essential to their full development and vitally important in preparation for adulthood. Although children are proficient at learning from one another, it is universally acknowledged that children need to learn the basic tenets of life and living from an adult. The bond that naturally forms during early childhood between a child and his parents or his main caregivers is generally believed to provide the foundation for relationships in later life. Although the relationship between a child and his parents is variable throughout his childhood, it retains a fair degree of importance: children learn from their parents how to deal with stress and anxiety, as parents represent a secure base or zone in which the child feels protected. Children copy parental behaviour and attitudes and they model themselves on their parents. In addition, adult authority is essential to learning the distinction between right and wrong, good and bad: elements of growing up which are equally seen to be vital to the development of children. Taking the above into consideration, it may be concluded that the absence of a parent or adult caregiver is likely to lead to children failing to gain much-needed skills for life.

The care for a child is considered to be a responsibility of parents or other legal guardians. This may be derived from the fact that teenage parenthood is discouraged worldwide. For inexplicable reasons, in the situation of child-headed households, placing the role of main caregiver on a child a young person, by any standards lacking maturity is supposedly unacceptable. Although children play an important role in the upbringing of younger siblings in many African countries, a child as head of a family has to be considered as a deviation from the norm. Care provided by child heads is mostly multi-dimensional as it encompasses care for self, for siblings and in some instances for one or more incapacitated adults. Therefore children should not be compelled or manipulated into assuming an adult role for which they as children are not prepared, as this constitutes a clear violation of their rights. All children need time to be children; however, children living in child headed households in particular the heads of the family are expected to carry adult roles and responsibilities, at the cost of their childhood and are therefore forced into premature adulthood. In addition, children who are looked after by another child rather than by an adult do not receive the kind of alternative care they are entitled to.

Children in child-headed households are generally traumatised by the loss or serious illness of a parent. It therefore cannot and should not be considered to be in children's best interests to remain without an adult caregiver unless community care givers, government and NGOs put in place strategies that address the children's welfare without undermining their opportunities and development in education, health and socially. Adults, providing day-to-day protection and care, are of paramount importance to all children and depriving children of adult parental care should therefore be regarded as a violation of Article 3 Convention on the Rights of the Child (CRC) and Article 4 African Charter on the Rights and Welfare of the Child (ACRWC).

## **14. Recommendations**

### *14.1. Adequate Treatment for HIV and AIDS Patients*

Providing those suffering from HIV and AIDS and related illnesses with adequate treatment is a measure by which parents remain in a position to care for their children. When parents' lives are not cut short unnecessarily and when they are enabled to provide their children with adequate care, the number of child headed households will decrease significantly. Home-based care programmes should be available for households in which the parent or primary caregiver is suffering from HIV and AIDS. Bringing these households into a care system at an early stage, allows for the provision of assistance that the family requires at that point in time, as well as for the timely planning of the period to follow. The latter should include clarification of inheritance rights, the appointment of a legal guardian and acquisition of birth certificates and other formal documents. When it becomes clearer that parents are terminally ill, drawing up a will is a measure which can prevent a void where the law does not provide sufficient safeguards.

### *14.2. Investment in Financial and Human Resources*

Meeting child headed households obligations deriving from the CRC and the ACRWC requires that States allocate sufficient budget and resources to sectors concerning and affecting children. In relation to alternative care, the Government of Zimbabwe has to acknowledge first and foremost that providing adequate care options for children in need of alternative care is of paramount importance to children and to society as a whole and that it is vital to make available sufficient resources. It should be noted that the combination of political will and resources is a prerequisite for successful implementation. A substantial part of these financial resources will have to be allocated to the training of professional and kinship caregivers.

The shortage of adequately trained staff such as social workers and community care givers forms an insurmountable obstacle to implementation of the CRC and the ACRWC. In addition, legal recognition of child headed households creates obligations for governments; courts must be available and accessible to recognise a household as child headed, social workers are needed to assess the children's situation, governments should ensure that suitable and sufficient supervising adults are available and that these

supervisors are allocated to child headed households and sufficient financial support should be provided to these households. Taking into consideration that in most countries an adequate and fully functioning alternative care system is not in place, it would be reasonable to question whether States are currently adequately equipped to fulfil these obligations.

#### 14.3. Legal Recognition of Child-headed Households

Interventions to avoid the emergence of child headed households should be at the forefront of policies relating to alternative care for children. Rules and regulations aimed at legal recognition of child headed households in order to provide children access to social security and other necessities may be considered as an interim measure for a maximum period of three to five years, allowing governments to improve their care system in a drive to comply with the proposed framework for alternative care as well as with the UN Guidelines. However, the unconditional legal recognition of child headed households should be avoided at all times as child-headed households should not form an integral part of countries' alternative care mechanisms.

#### 14.4. Adequate Alternative Care System

With kinship care being the most practised form of alternative care, the traditional role of the extended family must be honoured. Alternative care should meet the psycho-emotional, social and other needs of children and caregivers should be provided with financial support and supportive social services by the State. The right to alternative care should be regarded as a universal right. Providing children in need with alternative care is one of the obligations a State has a duty to fulfil. Irrespective of whether children grow up in a developing or in a developed country, they have the right to protection and care provided by an adult; any child deprived of the care and protection of his biological parents should not be denied this right.

Home based care programmes should be available for households in which the parent or primary caregiver is suffering from HIV/AIDS. Bringing these households into a care system at an early stage, allows for the provision of assistance that the family requires at that point in time, as well as for the timely planning of the period to follow. The latter should include clarification of inheritance rights, the appointment of a legal guardian and acquisition of birth certificates and other formal documents. When it becomes clear that parents are terminally ill, drawing up a will is a measure which can prevent a void where the law does not provide sufficient safeguards.

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