# ASSESSMENT OF THE IMPACT OF HIV/AIDS ON FEMALE CHILDHEADED HOUSEHOLDS: THE CASE OF TEN FEMALE CHILD-HEADED HOUSEHOLDS IN ADAMA TOWN, ETHIOPIA

**A THESIS**

**SUBMITTED TO INDIRA GANDHI NATIONAL OPEN UNIVERSITY (IGNOU) IN PARTIAL FULFILLEMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER OF ARTS IN RURAL DEVELOPMENT**

**BY**

**ALEM EZEZEW**

**ADDIS ABABA, ETHIOPIA**

**NOVEMBER, 2013**

# DECLARATION

I declare that **ASSESSMENT OF THE IMPACT OF HIV/AIDS ON FEMALE CHILD- HEADED HOUSEHOLDS: THE CASE OF TEN FEMALE CHILD HEADED HOUSEHOLDS IN ADAMA TOWN** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

Signed: Date:

**Alem Ezezew** **September 2013**

# CERTIFICATE

This is to certify that Mrs. Alem Ezezew student of M.A (RD) from Indira Gandhi National Open University, New Delhi was working under my supervision and guidance for her Project Work for the Course MARDP-001.Her Project Work entitled

ASSESSMENT OF THE IMPACT OF HIV/AIDS ON FEMALE CHILDHEADED HOUSEHOLDS: THE CASE OF TEN FEMALE CHILD-HEADED HOUSEHOLDS IN ADAMA TOWN, ETHIOPIA

Which she is submitting is her genuine and original work

Place: signature

Date: Name

Address of the Supervisor

## ACKNOWLEDGEMENTS

*I express my sincere thanks to all who assisted me in one way or another. Most importantly, I would like to extend my deepest gratitude and appreciation to my thesis Advisor* Dr. Mengistu uhullukaa *his guidance; comments and supervision with patience, encouragement, at different stages of the research. He really sacrificed his precious time in reading and reviewing many drafts and final output of my work.*

*I extend special thanks to different governmental and nongovernmental organizations and Community Based organizations involved in this thesis work for facilitating the necessary condition and helping me to collect the data. My thanks also go to all the informants/participants in the case study, interview and focus group discussions who gave me the necessary information without hesitation.*

# TABLE OF CONTENTS

**DECLARATION** .... 3
**CERTIFICATE** .... 4

**ACKNOWLEDGEMENTS** .... 5
**TABLE OF CONTENTS** .... 6
LIST OF TABLES .... 10
LIST OF FIGURES .... 11
LIST OF ACRONYMS .... 12
ABSTRACT .... 14
**CHAPTER ONE: INTRODUCTION** .... 17
1.1 Background and Purpose of the Research .... 17
1.2 Research Objectives .... 19
1.3 Main Research Question .... 19
1.4 Subsidiary Questions .... 19
1.5 Operational Definitions .... 20
1.6 Problem Statement .... 23
1.7 Limitations of the Study .... 24
**CHAPTER TWO: CONCEPTS AND THEORETICAL APPROACH** .... 25
2.1 Concepts .... 25
2.1.1 Child: .... 25
2.1.2 HIV/AIDS: .... 25
2.1.3 Households: .... 26
2.1.4 Female Child- headed Household: .... 26
2.1.6 Poverty and Being Orphans: .... 26
2.2. Theoretical Approach .... 27
**CHAPTER THREE: LITERATURE REVIEW** .... 29

3.1 The Impact of HIV/AIDS on Female Headed Households ... 29
3.1.1 The Impact of HIV/AIDS Epidemic in Ethiopia ... 30
3.1.2 Formation of Female Headed Households: Underlying Causes ... 31
3.1.3 Female Headed Households: Challenges and Consequences ... 33
3.2 The Social Support Mechanisms: CBOs and Iddir ... 41
3.2.1 The Role of Civil Society to Promote the Wellbeing of Orphaned Households ... 41
3.2.2 The Role of Child Focused NGOs to Promote the Wellbeing of Orphaned Households ... 42
3.3. Child Rights and Legal Guidelines ... 43
3.3.1 Review of Child Rights Declaration and Conventions ... 43
3.3.2 Review of the International Documents ... 45
3.3.3 The African Charter on Child Rights ... 45
3.3.4 Review of Ethiopian Laws and Policies Regarding Children ... 46
**CHAPTER FOUR: METHODOLOGY OF THE STUDY** ... 50
4.1 Study Design ... 50
4.1.1 Study Area: ... 50
4.1.2 Participants: ... 50
4.2 Method of Data Collection ... 51
4.2.1 Semi-structured Interview ... 51
4.2.2 Key Informant Interview ... 51
4.2.3 Focus Group Discussion ... 52
4.3 Sampling Technique ... 53
4.4. Ethical Consideration ... 54
4.5 Analysis Strategy ... 54
**CHAPTER FIVE: DATA ANALYSIS, INTERPRETATION AND FINDINGS** ... 57
5.2 Data Analysis and Interpretation ... 57

5.2.1 Characteristics of Participants of the Study ... 57
5.2.2 Thematic Coding ... 61
5.3 Findings of the Study ... 63
5.3.1 Being Head of a Household: Assuming Parental Responsibilities ... 63
5.3.2 Perception of Female Child as Head of Household ... 68
5.3.3 Leadership Strategy of Female Child as Head of Household ... 70
5.3.4 Challenges of Care Giving as Head of Household ... 71
5.3.5 Strategies for Coping as Female child-headed Household ... 75
5.3.6 Views on the Future as Female child Headed Household ... 78
5.4 Perceptions of Siblings of Female Child-headed Households ... 79
5.4.1 Perceptions of Siblings towards the Local Community ... 80
5.4.2 Perceptions of Siblings towards Their Deceased Parents ... 81
5.4.3 Perceptions of Siblings towards Existing Care Taker (Female Child-headed Household) ... 82
5.4.4 Day-to-Day Challenges: Problems versus Perceived Needs ... 83
5.4.5 Views on the Future ... 84
5.5 The Role of Child Focused NGOs & CBOs: Addressing the Needs of FCHHs ... 86
5.3.1 Relevance of the Care and Support Services ... 88
5.3.2. Beneficiary Selection Criteria: ... 88
5.3.3 Participation of the Local Community ... 89
5.3.4. Major Limitations of the Programme ... 91
**CHAPTER SIX: SUMMARY, CONCLUSION AND RECOMMENDATIONS** ... 94
6.2 Summary ... 94
6.3 Conclusion ... 97
6.3.1 Conclusion as per Objective One ... 98
6.3.2 Conclusion as per Objective 2 ... 99

6.3.3 Conclusion as per Objective 3: ... 100

6.3.4 Developmental Theory and Child Household Heads ... 101

6. 4 Recommendations ... 103

**Annexes** ... 113

Annex 1: Themes by Sub-categories ... 113

Annex 2: List of Research Tools ... 115

2.1. Semi-Structured Interview (Case-study) ... 115

2.2. Focus Group Discussion Guide (representatives of government offices and other stakeholders working close to the Female Child-Headed households) ... 118

2.3 Focus Group Discussion Guide (with Siblings of Female Child-Headed Households) 119

2.4. Key Informants Interview Guide (with NGOs, CBOs and GOs representatives) ... 120

Annex 3: Informed Consent Form ... 122

**Annex 4: A Brief Description of Participants of Case Study** ... 123

**Annex 5: Summary of Responses of Case Study Participants** ... 125

Being Head of a Household: Assuming Parental Responsibilities ... 125

Being Head of a Household: Assuming Parental Responsibilities ... 126

Being Head of a Household: Assuming Parental Responsibilities ... 127

Being Head of a Household: Assuming Parental Responsibilities ... 127

Being Head of a Household: Assuming Parental Responsibilities ... 128

Being Head of a Household: Assuming Parental Responsibilities ... 130

Leadership Strategy of Female Child as Head of Household ... 130

# LIST OF TABLES

***Table 1: Characteristics of the case studies*...........................................................................................*57***

***Table 2: Characteristics of key informants of the study* ............................................................................*59***

Table 3: Summary characteristics of FGD participants 60

## LIST OF FIGURES

*Figure 1****: Conceptual framework of the experiences of a female child impacted by HIV/AIDS ............27***

## LIST OF ACRONYMS

ACRWC..............................African Charter on the Rights and Welfare of the Child
AIDS..................................Acquired Immunodeficiency Syndrome
ART....................................Antiretroviral Treatment
CBOs..................................Community Based Organizations
CEDAW..............................Convention on the Elimination of Discrimination Against Women
CRC....................................Child Rights Convention
CSA....................................Central Statistics Authority
EPI .....................................Expanded Programme on Immunization
FAO....................................Food and Agricultural Organization
FCHHs.................................Female Child-Headed Households
FGAE.................................Family Guidance Association of Ethiopia
FGM...................................Female Genital Mutilation
HAPCO..............................HIV/AIDS Prevention and Control Office
HBC....................................Home Based Care
HH.....................................Household
HIV.....................................Human Immunodeficiency Virus
IGAs...................................Income Generating Activities
IPA.....................................Interpretative phenomenological Analysis
MDGs.................................Millennium Development Goals
MoLSA...............................Ministry of Labor and Social Affairs
MOWYCA..........................Ministry of Women, Youth and Children Affaires
NGO...................................Non-Governmental Organization
OVC...................................Orphans and Vulnerable Children
PMTCT...............................Prevention of Mother to Child Transmission
STIs.....................................Sexually Transmitted Infectious
UNAIDS.............................Joint United Nations Programme on HIV/AIDS
UNCRC..............................United Nations Convention on the Rights of the Child
UNDP.................................United Nations Development Programme
UNECA ..............................United Nations Economic Commission for Africa
UNESCO ...........................United Nations Educational, Scientific and Cultural Organization

UNFPA................................United Nations Population Fund
UNICEF ..............................United Nations Children's Fund
USAID.................................United States Agency for International Aid
WHO...................................World Health Organization

***ABSTRACT***

*The HIV/AIDS epidemic is tearing away at the social, cultural and economic fabric of families, communities and nations. It is resulting in distorted population structures, low life expectancy and declining economic growth. The greatest tragedy wrought by the epidemic has been the staggering population of orphans left behind in the wake of parental death in large numbers. Once left parentless, some orphans were absorbed by the extended family, while others make their way into institutional care or onto the street. However, many of them establish a household by themselves where the eldest sibling takes the household headship in what is termed child-headed household. The impact of HIV/AIDS had been studied from different perspectives, such as, in relation to work force, home based care, health facility, FCHH, stigma and discrimination. However, the literature that deals with the impact of the pandemic on female child-headed households is very scarce in Ethiopia in general and in the study area in particular. Thus, this study presents an assessment of the impact of HIV/AIDS on female child-headed households, by studying the psychological problems and child right situation, exploring the challenges faced by female child-headed households in carrying the responsibilities of household headship and coping strategies. It intends to identify perceptions of children towards their caregivers, the people in the community and the future. The study also assessed the role of child-focused organizations in addressing the need of child-headed households in the study area and the relevance of the different services and supports they have been providing to the children. Ten semi-structured interviews were conducted with female children carrying responsibility for household in Adama town, Eastern Oromoiya zone of Oromoiya National Regional State. The selection of respondents was based on purposive*

*sampling. FGDs and KIIs were used along with representatives of government sector, NGOs and siblings of women child-headed household to generate qualitative data. In addition, secondary data were collected from relevant documents from woreda health office and other sources. The data were analyzed by using strategy of Interpretative Phenomenological Analysis (IPA). The study showed that female child-headed households face tremendous emotional and psychological challenges, and live with the constant memory of their departed parents, who often died slowly and painfully. The majority of them experience loneliness and stress associated with shouldering an adult role at a young age. The study also identified that the major challenges faced by female child- headed households are responsibility towards younger siblings and the obligation to take the place of the deceased parents ,concern for surviving in the face of economic and social hardship, grappling with multiple and competing responsibilities, and helplessness, uncertainty about personal safety and family disintegration and discipline. The study revealed that female child-headed households used various types of strategies for coping with the impact of HIV/AIDS. The major ones include searching for assistance from the charity organizations, selling household assets and withdrawing savings. The study showed that while the involvement of community and child-focused NGOs and CBOs working in orphaned and vulnerable children support services generally seem encouraging, even though the assistance was limited and the selection criteria of beneficiaries was not gender sensitive. It is evident from the findings from this study that the female child-headed households face a number of challenges, which include shortage of food, lack of access to education, insufficient health services, sexual abuse, psychosocial impact, , pubertal adjustment, burden of carrying responsibilities, etc. They,*

*however, have not been able to address these challenges effectively. Thus, this study recommends that communities need to mobilize resources to assist female child-headed households and children living with them to optimize their quality of life and future prospects in mitigating the impacts of HIV/AIDS. Moreover, there is clearly a need for programs and skills that enhance the children's ability to manage households in areas such as management, conflict resolution, and effective utilization of limited household resources and so on. The study further recommended that all stakeholders providing support to child-headed households need to assess the gender dimensions of HIV/AIDS impact before undertaking any intervention programs since it was discovered from the study that female child headed households have been vulnerable to biological, cultural and sexual challenges.*

***Key words:*** *HIV/AIDS; children; orphans; Female child-headed households; coping strategies; vulnerable children; children affected by AIDS; children's rights; child protection; child welfare policy; community child care capacity; psychosocial support*

# CHAPTER ONE: INTRODUCTION

## 1.1 Background and Purpose of the Research

The population of Ethiopia was estimated to reach 80 million in 2012 (CSA, 2003). While the current adult HIV prevalence rate is 1.4, the impact of AIDS has been worse. As a significant number of people who were previously infected have become patients, some died of AIDS. The pandemic has posed serious challenges. In a country where the age structure of the population is largely young, the death of parents will leave children alone. The problems of orphans in Ethiopia are multifaceted as it is interwoven with abject poverty on the one hand, and is adjoined by collective social system, on the other.

Orphans are children with one or both parents died whereas foster children are children under age 18 living in households with neither their mother nor their father present. Both foster children and orphans are of concern because they are liable to be neglected or exploited if no parent is present. As most of these children have to do child labor in quest of livelihood, they are prone to physical and sexual abuses.

According to the most recent DHS report of Ethiopia (CSA, 2012), 19 percent of households have foster children, single orphans (one parent dead) are present in 11 percent of households, whereas double orphans (both parents dead) are present in 1 percent of households.

A study by Foster and Williamson cited in Tshenkeng (2009) argued that the loss of a mother appears more detrimental than that of a father. They observe that maternal orphan hood has proved to be more distressing than paternal orphan hood. The same authors also reported that high prevalence of orphan hood might be due to migration rather than a high incidence of parental death. Urban-rural migration occurs because of the "going-home-to-die" phenomenon.

The surviving family and the extended family are also be affected socially and psychologically. Firstly, they are affected psychologically because of the stigma. Secondly, as soon as parents die, children are likely to be orphaned which results in a burden primarily to r the extended family. When children are not able to live alone because of the household's conditions, they leave they leave the house to join the extended family or if they do not have access to it, to an institution which supports children. However, in the Ethiopian context, since there are few institutions, many of the orphans are likely to end up becoming street children and prostitutes.

Girls may get engaged in high-risk activities such as sex work, and boys in criminal activities for survival.

Furthermore, HIV/AIDS changes the household structure and family size. After the death of the breadwinner, different types of households originate, such as female headed, female-child headed, grandparent headed and dissolved households.

The purpose of this research was, therefore, to identify female children orphaned by the pandemic of HIV/AIDS, especially, female child headed households, and then study their livelihood and the psychosocial stresses, as well as, the coping mechanisms.

### *1.2 Research Objectives*

The main aim of this thesis was to observe the psychosocial stresses and coping strategies by female orphaned children impacted by the AIDS pandemic. The specific objectives were:

1) To assess the psychosocial problems and child rights situations among Female-child- headed households orphaned by HIV/AIDS;
2) To explore the challenges faced by young girls in executing household headship role and in adjusting to pubertal changes eminent during adolescence; and
3) To identify social and economic networks of the households that are used as coping mechanism.

### 1.3 Main Research Question

The main question that this study aims to answer is, “What is the impact of HIV/AIDS on female child-headed households in Adama town of East Oromoiya zone Oromoiya National Regional State?”

### 1.4 Subsidiary Questions

1. What are the psychosocial stresses experienced by female children living with the impact of HIV/AIDS and its concomitant sufferings?
2. How does these female children orphaned by the pandemic cope the stresses?

3. In what ways does gender interplay with the prevailing household burdens, including care-giving and sustaining livelihood?
4. What are the main means of livelihood of the household before and after the HIV/AIDS impact?
5. How does the female child heading the household perceive assuming parental role and nurturing younger siblings?
6. What is the experience of the orphaned young girl adjusting to pubertal changes?
7. How does the young girl heading the household understand herself , respond to stigma attached to AIDS and view her future?

## 1.5 Operational Definitions

**Bereavement:** Feelings of loss of a significant family member including parents or siblings often accompanied by hopelessness, distress, confusion, and feelings of being deserted Geldard (2002:88)

**Child rights:** The entitlements to education, food and shelter that children should get from families, community and Government encompassing all the conditions to survival, best interest, participation and nondiscrimination as stipulated in the African Charter of the CRC child (MoLSA and UNICEF 2005).

**Coping:** is about the ways in which we all recognize that our normal expectations of how life is and ought to be are 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 culturally significant for us. (UNAIDS 2007:92)

**Gender:** refers to socially constructed roles of women and men ascribed to them based on their sex. Gender roles depend on a particular socioeconomic, political and cultural context. They are learned and vary widely within and between cultures and can change (Common Wealth Secretariat, 2002).

**Helping behavior:** A psychosocial behavior or tendency to avail help for a person under emergency, in the psychology literature sometimes called 'altruistic behavior' of an individual or group. (Benjamin et al 2005: 555-564).

**Household:** Any unit of habitual residence where a group of people live in the same house, providing help for each other and often sharing meals. Household members also include those who are temporarily absent from the household but have returned at some point in the last year and are expected to resume residence in the household in the future (Sloth-Nielsen (2004:1)

**Iddir:** A community based association established on voluntary basis for supporting each other with special attention to burial of the dead (from this research)

**Impact of AIDS:** In this paper, AIDS impact refers to the detrimental effects of the pandemic including parental lose, dwindling family income, family disintegration, the girl child's disruption from school and her increased vulnerabilities (Hunter and Willamson 2000:1).

**Kebele:** One of the 21 smallest administrative units under the City Administration of Adama town (from this research)

**Livelihood:** the capabilities, assets and activities required in order to acquire a means of living Collins 1998:15-17),

**Orphan:** A child less than 18 years of age who has lost one or both parents due to HIV/AIDS (UNICEF/UNAIDS 1999)

**Vulnerability:** In the context of HIV/AIDS, vulnerability refers to children living in a household where the duty bearer is ill with AIDS. It also refers to children living in a household that takes in orphaned children (Loening-Voysey & Wilson, 2001.

**Poverty:** Poverty is economic condition in which people lack sufficient income to obtain certain minimal levels of health services, food, housing, clothing, and education, generally recognized as necessary to ensure an adequate standard of living (Barnett and Alen 2006).

**Stakeholders:** persons, groups or institutions with interests in a program or activity, because it will affect them in some way. In this paper, these include Iddirs, religious institutions, and the community (Brennan and Rankin 2004).

**Stress:** Discomfort or a state of restlessness resulting from unpleasant life event and hectic situation, such as, losing a parent due to AIDS, thus the child is confused, anxious and depressed (source?) ) (Mahati 2006:12).

**Vulnerable children:** a child who is below the age of 18 who has been, is in, or is likely to be in a risky situation, where he/she is likely to suffer significant physical, emotional or mental harm. According to MoWCYA (2010), a vulnerable child is one 'whose survival, care, protection or development might have been jeopardized due to a particular condition, and who is found in a situation that precludes the fulfillment of his or her rights.

## 1.6 Problem Statement

The impact of HIV/AIDS had been researched for a long time from various perspectives. Indeed, the pandemic entails human lose, high medical cost, social and economic problems. Yet, its impact on female-headed households who were orphaned by the pandemic is daunting and more complex.

Traditional gender norms still prevail in Ethiopia. Women assume the triple roles of production, reproduction and community responsibilities since their childhood. In the realm of inequitable gender relations, caring becomes the sole burden of children in households where parents had deceased due to AIDS. Girl children are expected to take on a greater proportion of the household tasks than their brothers, often at the expense of their education (Grainger, Webb, & Elliott, 2001, p.37).

Apart from household burdens, feelings of bereavement compounded by social stigma are affecting female children in many ways. Exploring the specific psychosocial experiences of young girls is of paramount importance to identify coping strategies, thereby, will help shed light to design better intervention. The impact of HIV/AIDS had been studied from various perspectives such as in relation to work force, home-based care, health facility, FCHH, stigma and discrimination. However, the literature that deals with the impact of AIDS on Female-child headed households from gender perspective is scarce. Investigating care giving from the gender lens may add evidence in this respect.

## 1.7 Limitations of the Study

The study deals with the impacts of HIV/AIDS on the psychosocial experiences, emotional state, and livelihood challenges of female children who assumed household headship. Of the regional and zonal towns, Adama was selected purposively for two reasonsfirst, it has been one of the high prevalence areas, and second, it was one of the places where care and support services were given early by NGOs and communities. Thus, the study had delimited only to one town. As is the case with most qualitative research design, this case study is peculiar and limited to this group of participants. Taylor and Bogdan (1984) had stated that one of the principles governing qualitative research approach is that the results are not generalized to the whole or a specific population. Hence, the apparent limitation of the study is generalization of evidence from case histories would not be sufficient to apply for the entire population.

# CHAPTER TWO: CONCEPTS AND THEORETICAL APPROACH

## 2.1 Concepts

### 2.1.1 Child:

A child is a person under the age of 18 years. For the sake of this study, the child refers to both the female child and her younger siblings below 18 years. At times, the paper uses the terms the girl child and the young girl to refer to the household heading child below 14 years, and the adolescent girl between 14 and 17 years who are likely to have seen most pubertal changes. According to Smart (2003), in the context of HIV/AIDS, the definition of a child has particular relevance in light of issues such as the age at which compulsory education ends. It also addresses any difference between girls and boys, for example, in relation to marriage and the age of sexual consent, legal capacity to inherit and to conduct property transactions and the ability to lodge complaints or seek redress before a court or other authority.

### 2.1.2 HIV/AIDS:

AIDS is a clinical syndrome (a group of various illnesses that together characterize a disease resulting from damage to the immune system caused by infection with the human immunodeficiency virus (HIV). HIV, which causes acquired immune deficiency syndrome (AIDS), principally attacks T-4 lymphocytes, a vital part of the human immune system. As a result, the body's ability to resist opportunistic viral, bacterial, fungal, protozoal, and other infection is greatly weakened (quoted in Brennan and Rankin 2004:1).

### 2.1.3 Households:

A household (in this study) is a family unit consisting of orphaned children who live together sharing the same housing and resources for a livelihood. In some cases, the unit may also house a seriously sick parent as well as one or a couple of extended family member usually the elderly.

### 2.1.4 Female Child- headed Household:

This refers to a girl child of 10 to 12 years of age who is orphaned by the pandemic along with her elder or younger siblings and because of since the illness or death of a parent(s) has assumed family headship.

### 2.1.6 Poverty and Being Orphans:

The English word "orphan" is derived from Greek and Latin roots meaning "a child bereaved by the death of one or both parents". UNAIDS ( (1999).)defines an orphan as a child under 15 years of age who has lost her or his mother (maternal orphan) or both parents (double orphan) to AIDS. In this paper, children under the age of 18 who have lost either one or both parents are considered orphans. According to Seyoum & Aman (2007), Ethiopian children deprived of their family environment are classified into three categories: orphans bereft of both parents, children who do not live with their biological mothers and children who reside in single-adult households. Poverty and 'being orphaned' are highly interlinked. The impact of HIV/AIDS on children and families had been compounded by the fact that many families live in communities, which are already disadvantaged by poverty, poor infrastructure, and limited access to basic services (Foster & Williamson, 2000, p.5).

### *2.2. Theoretical Approach*

The illustration in Figure 1 depicts the female child in the centre. The child who lost her parents due to the AIDS pandemic becomes head of a household. This headship role per se brings both labor burdens and emotional challenges. Not yet recuperated from bereavement, the young girl is now immersed with livelihood concerns and caring for younger siblings. The female child has been affected not merely for being orphaned by AIDS but also by suffering from its concomitant effects. Apart from experiencing psychosocial stresses currently, she is further prone to far-reaching consequences. The clouded callout signifies the immediate while the end flowchart displays long-term impacts.

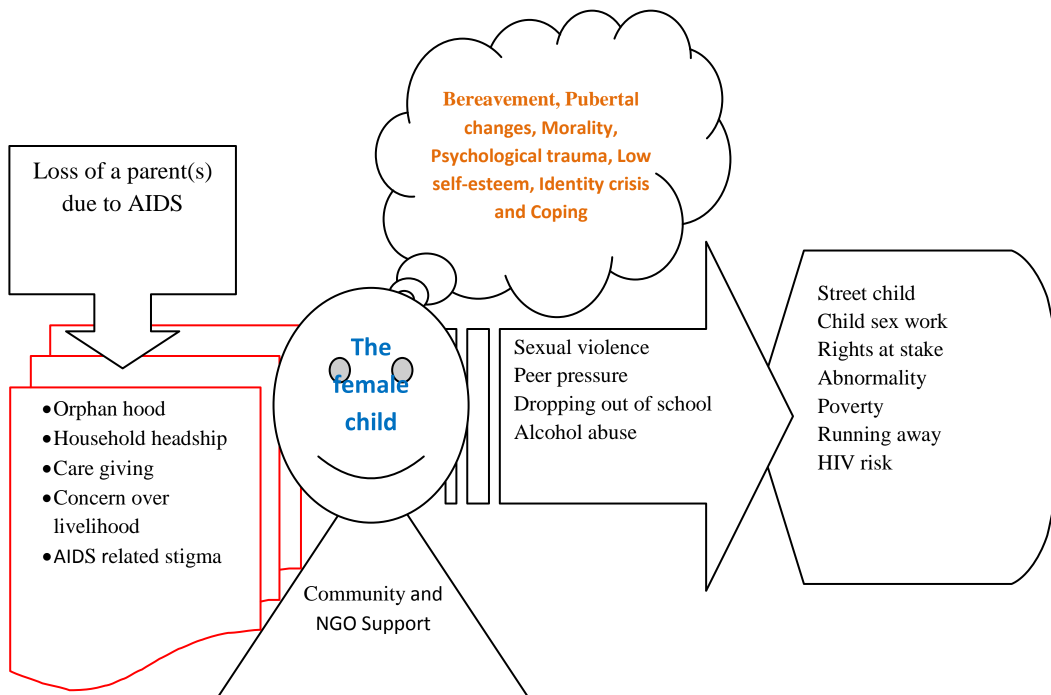


**Figure 1: Conceptual framework of the experiences of a female child carrying Responsibility for Child-headed households because of parental death due to HIV/AIDS** (Nyamukapa.2008)

As a social being, the female child may get support from the community or NGO. Likewise, as a growing being, she is not a passive victim. Embarking on adolescence, she has to adjust with pubertal changes. While faced with the developmental task of transition to adulthood, she tries to cope with stressors on the one hand and find a means of income to sustain the livelihood of the household. In this quest, she might be compelled to engage in transactional sex or some type of child labor. These situations leave the young girl prone to gender based violence. Since both forced and transactional sex is usually unsafe, her health will be at risk. Eventually she may acquire HIV; hence, eventually the impact of HIV/AIDS remains vicious.

In consistent with this, Nyamukapa et al.(2008) tested a conceptual framework by surveying 5,321 children of age 12 to 17 years in Zimbabwe. These HIV associated orphans experienced psychosocial distress including depression, anxiety and low self-esteem. They have also found that chronic trauma and low qualifications and skills could translate into limited employment prospects, early parenting, unstable relationships, social isolation, poverty, and behaviors that predispose toward poor health outcomes, including HIV infection.

In light of theories of social psychology, the female child heading a household faces chronic stresses due to parental death. According to psycho -analysis, these children, who are in the age range of 12 to 17 years, reach the time when attraction to the opposite sex begins, hence a mature heterosexual relationship manifests. Indeed, the growing teenage girl experiences pubertal changes. Most girls in this age range will see menarche- the first menstruation. This poses various questions especially if the girl is not oriented how to

deal with this eminent biological change. Likewise, from the psychosocial perspective, the time is a period of identity crisis thus the adolescent girl will either form her identity or face confusion. In the absence of a clear role model, this process may result in identity crisis.

On the other hand, this developmental stage is supposed to be a time when the adolescent reaches a post conventional stage of morality based on rules and principles. However, Carol Giligan (2000) proposes a differing view of morality. She coined the morality of women (the psychology of caring) in which unlike men, women are said to give higher values to the care and welfare of others. This gender dimension of morality better explains the state of a female child who usually sacrifices her career prospect to help the sick and look after her younger siblings.

# CHAPTER THREE: LITERATURE REVIEW

## 3.1 The Impact of HIV/AIDS on Female Headed Households

In addition to trauma of losing one or both parents, being orphaned because of HIV, increases vulnerability in many ways. Loss of a parent leads to a significant decline in the standard of living and increases the likelihood of exploitation. Where both parents die, children become heads of households assuming enormous burdens at an early stage (WHO, 2004). One of the most obvious impacts of the epidemic is increase in the work performed by children sometimes as young as five years old. Annet (2006, p.24) contends

that the workload of children starts when parents become sick and increases when children become orphaned.

### 3.1.1 The Impact of HIV/AIDS Epidemic in Ethiopia

In Ethiopia, the number of orphans and the proportion of AIDS-related orphaning continue to grow. A CSA (2003) report estimated that 12 per cent of the 4.6 million orphans in Ethiopia have lost one or both parents due to AIDS-related causes. In 2009, this figure had decreased to 3.8 million (CSA, 2009)..

About one-quarter (26 percent) of Ethiopian households has been headed by women, a slight increase from 23 percent in 2005. Average household size is 4.6 persons, which is slightly lower than the average of 5.0 persons per household reported in 2005. Urban households have fewer members than rural households. In urban areas the average household size is 3.7 persons, compared with 4.9 persons in rural areas. According to Aster (2005) contends that children do not only become head of the household, but also become responsible beyond their capacity since they were not mature enough to assume responsibility. This has an impact on their education in general and for their future life in particular.

Data from the Ethiopian EDHS (2005) showed that 26% of households in Ethiopia are Female-child headed. An important consequence of HIV/AIDS for orphans and other children made vulnerable by AIDS is exclusion from education.

The EDHS report (2011) had shown that children with both parents dead are less likely to attend school (69 percent) than children who are living with at least one parent (76 percent). Children in female child-headed households find it hard to go to school because of lack of money and scholastic materials. Most of these children get poor scores in some subjects, especially those that require extra time and help, which can be traced to lack of adult pedagogic support at home.

#### 3.1.2 Formation of Female Headed Households: Underlying Causes

According to Shimelis (2010), following the death of their parents, many children may be integrated into the extended family, or be admitted into institutional care. However, when these options fail, in many cases, and even when these options are available, children decide , no doubt reluctantly, the rational and conscious choice to establish a female child-headed household. Female-child headed households are more likely to be the result of a maternal rather than a paternal death. Since in AIDS-affected communities, the father is likely either to have predeceased his wife or to have abandoned the household on the death of his wife (Grainger, Webb & Elliott, 2001).

The emergence of female child-headed households may occur due to absence of relatives to look after the children or the refusal of relatives to look after the orphans or preferred option of the children themselves. If it is easier to maintain the property and other assets in the family, the siblings will be able to remain together. If resources are insufficient and the orphans are mistreated by the guardians they move out to live alone.

Unfortunately, stigma is attached to those whose parents have died of AIDS. It is among the root reasons for some of those relatives who refuse to take care for orphans. Even though some children prefer to live by themselves, financial shortage and search for livelihood sometimes result in sibling disintegration from their original household (UNICEF/UNAIDS 1999).

A significant percentage of children affected by HIV and AIDS enjoy the protection of their extended families. However, the proportion of children living in female child-headed households in Ethiopia is above the average for sub-Saharan Africa; girls head many of them. Many of the girls are between the ages of 14 and 16 years (UNICEF 2006:4).

A study by Foster & Williamson (2000) showed that extended family safety nets has been weakened in more urbanized settings. As the traditional practice of orphan inheritance by uncles and aunts has lessened, the role played by alternate safety nets with care provided by grandparents or other relatives has increased.. Foster & Williamson (2000, p.4) argued that children who slip through the safety net may end up in a variety of vulnerable situations such as street and working children and female child-headed households.

According to some studies mentioned in Schatz, Madhavan, & Williams (2011), the primary reasons for female-headship have traditionally included male labor migration and non-marriage, a context that is connected to historical patterns of patriarchy. These authors, however, stated that female-headship increasingly is connected to contemporary macro-economic conditions and premature death brought on by HIV/AIDS.

### 3.1.3 Female Headed Households: Challenges and Consequences

There is some evidence (e.g., UNAIDS & WHO, 1999) for a link between the AIDS epidemic and a rise in early marriage, early sexual activity and sexual abuse of young girls. Grainger, Webb, & Elliott (2001) argued that this might have been linked to the belief in many parts of Africa that young girls are less likely to be infected with HIV and are therefore safer to have sex with.

Being younger, these women may not have had the time to build up the social connections. Schatz, Madhavan, & Williams (2011, p.598) discussed that younger heads often struggle to find money for basic household needs. Many undertook informal work to supplement household income, but most seemed over- whelmed by household demands.

Shimelis (2010) contends that even if these children go to school, the majority does not attend regularly because they feel tired, have not enough food to sustain them during school hours, or because of frequent sickness. Most of those living in urban centers have to work late into the evening to make a living by selling cigarettes, roasted grain, lottery tickets, etc.

This is against child rights convention. Article 32 of the UN Convention on the Rights of the Child recognizes the right of children to be protected from economic exploitation and to be protected from performing any work that is hazardous, interferes with their

education, or is harmful to their health or physical, mental, spiritual, moral, or social development (UN General Assembly, 1989).

The definition of child labor includes:

(a) Children of an age group between 5 and 11 and who are not members of the household work with or without pay, or engaged in any other family work or did household chores for 28 hours or more; and

(b) Children aged 12-14 who worked for someone who are not members of the household, work with or without pay, or engaged in any other family work for 14 hours or more or did household chores for 28 hours or more (source?). Ministry of Justice 2007)

**Impacts of HIV on gender relations and norms**

The actual lives of women and men reveal that there is variation in personal, physical, social and economic power and capacities between them. This results in differential rates of risk, infection patterns, access to health knowledge and protection, intervention and management of illness (Commonwealth Secretariat, 2002).

The impact of AIDS on women is multifaceted. The existing inequality among men and women in combination with poverty and HIV/AIDS makes the lives of women worse than ever. In many countries, including Ethiopia, women are more vulnerable than men because of many factors, among others the main ones being biological, cultural, social and economic. Women are caregivers, producers, guardians of family life, face greater economic insecurity because women are more likely to be poor than men

(Commonwealth Secretariat, 2002). In addition, they have lesser entitlements to assets and savings, less secure employment, are uneducated, lack information, have little power in sexual negotiation, and so on.

The societal expectation that women will be the prime or only caregivers for their infected family members creates disproportionate social and economic burdens on them. According to Steinberg et al. (2002) in a study conducted in South Africa, in more than two thirds (68%) women or girls were the primary caregivers. These researchers also revealed that of these caregivers, 7% of them were younger than 18 years. Aster (2005), who studied 100 households and 50 orphans in 2 kebeles of Adama found out that 15 children (30%) were found to care for themselves and siblings, and 32 percent were living with their grandmothers. Although the majority of these households are poor, her study confirmed that the extended family networks are still absorbing these children.

In Ethiopia, girls, who lost one or both parents, are mostly forced to take care of the household and other siblings. In case of shortage of income, they are involved in income generating activities, such as being house cleaner and in risky works like prostitution. Sometimes, they are also vulnerable to danger of raping by a member of the extended family who was supposed to be responsible to take care of the orphans. A study by Shimelis (2010), who found that household heading children, in most cases, engage in hazardous labor in exchange for food, or trade sex for food, in the case of girls. The same source revealed that a substantial number of girls in female child-headed

households have faced rape or attempted rape on numerous occasions. Finally, girls, like their parents, are also exposed to HIV infection.

In the household, women are the most vulnerable because of many reasons. They are responsible to care for the sick, for doing domestic work, and also to engage in income generating activities, such as, sex work and being housemaids. Therefore, the impact of HIV/AIDS and the coping mechanism of the households depend on different circumstances.

Women—mothers, grandmothers, wives, daughters, and aunts—are the most likely to become the primary care givers for the sick and for orphaned children, whether within their own homes or beyond (Schatz, Madhavan & Williams, 2011). In this role, women heads are likely to take on much of the financial, emotional, and physical responsibilities of care giving and sustaining households after an AIDS-death occurs within their own household or in households of their kin. As studies conducted by Foster & Williamson (2000) reveal, high rates of female-headed households found in poorer localities in Zambia. Research carried out in Uganda in 1990s showed that food insecurity and malnutrition ranked foremost among the immediate problems faced by female-headed AIDS affected households (UNAIDS, 2006).

Gender inequality exacerbates the problem of female-headed households for so many reasons. According to Nkomo (2006), female children unequivocally carry the burden of household responsibilities. Male children, on the other hand, are expected to find a job outside the home in order to generate income. PEPFAR / USAID (2008) described GBV

both a cause and consequence of HIV infection. For example, girls and women, who are raped, may be infected with HIV. The fear of violence may prevent women from insisting on the use of condoms or other safe sex methods. Annet (2006) asserted that HIV and AIDS stigmatization compounded their situation further.

Grainger, Webb, & Elliott (2001) have shown a plethora of information regarding the impacts of HIV on gender. HIV/AIDS result in an increase in female-headed households, which tend to be poorer than male-headed households are. This in turn results in increased burden on women and young girls of caring for the sick and the growing numbers of orphans. Consequently, • where household income is declining, the education of girls is regarded as less important than that of boys. The impact also manifests in sexual and other physical abuse associated with HIV, particularly of younger girls. Another crucial gender dimension of HIV is the fact that men tend to abandon an HIV-positive partner, whereas women experience anger, and then ultimately accept an HIV-positive partner.

**Psychosocial Impacts**

Over time, orphaned children may develop a sense of relative deprivation as their poorer circumstances coupled with stigma and discrimination result in their continually having reduced access to services and material resources (Nyamukapa et. al., 2008.

As soon as one of the household members is infected by HIV/AIDS, the problem starts from psychological strain, being afraid of the existing stigma. In addition to this, income of the household will reduce because of lack of employment or increasing cost for health

care. Since income has been reduced, the expenditure for necessities will likely be reduced as well.

Long before a parent dies, children experience trauma and stress related to caring for terminally ill parents. Children are directly in the forefront of distress, frustration, and a sense of hopelessness. An earlier study in Ethiopia, as cited in Shimelis (2010), revealed that because of their limited capacity to articulate their health problems and because of not having come of 'age' to claim the right to access public health services, children in female child-headed households are very unlikely to get treatment for illnesses.

A study conducted by Erulkar & Abebaw (2009) surveyed 1,837 females of 10 to 19 years to see the role of social exclusion in sexual debut. They found out that social exclusion was significantly associated with higher likelihood of coerced first sex. In their study, social exclusion has been defined as limited or no participation in social, economic, and political life. Another study from Kenya highlighted psychosocial impacts resulting from parental death due to AIDS. For the orphans, loss of parent/s means loss of everything like love, hope, protection or security, care and support (Togom, 2009, p.27).

Tshenkeng (2009) argued that healthy identity development seems to relate to the establishment of a healthy relationship between parents and their children, which allows for individual freedom. The family can grant autonomy or feedback processes to either encourage or discourage individuality and innovation (Watson & Protinsky, 1998). Erikson (year?) implies that an environment comprising positive parental process as well as a supportive environment has a high probability of encouraging a healthy identity. A

healthy identity in this regard is a strong sense of how one perceives and defines him/herself.

**Coping with the Impacts of HIV/AIDS**

The coping mechanisms currently used by female child-headed households fall more into a survival reflex rather than a well-thought out and strategic means for reproducing a regular life cycle as in biological families (Shimelis, 2010, p.41).

The first coping mechanism of HIV/AIDS affected households is just to sit and see what will happen next. This is because they have already passed through severe resource constraints by the experience of AIDS deaths. Therefore, the capacity to respond in any meaningful way to overcome the difficulties now confronting the household can sometimes be beyond their capabilities. In this condition, the only thing they do is to sit and try to change nothing about their livelihood strategies.

However, in the case of Ethiopia, 'doing nothing' in most cases is not used as a coping mechanism. Instead, there are various coping strategies such as praying and using holy water for curing.  A case study conducted by Demele (2004) on 15 women living with the virus in Adama, had revealed that nearly all women used religion as a primary coping strategy. This study has also confirmed that affected individuals use holy water as their coping strategy.

The other coping mechanism is receiving help from relatives and neighbors, which is an important support to the efforts of households facing an adult death. However, it is unlikely that the infected ones can get help in poor countries like Ethiopia, as there are limited resources in most households.

In order to examine the coping mechanisms of Ethiopian HIV/AIDS affected households, a survey of selected 150 households in two Kebeles of the Addis Ketema sub-city was undertaken. According to the results of this study, all coping mechanisms identified by Gow and Desmond 2007was ‘doing nothing'. In addition to these mechanisms, as mentioned earlier, some individuals and households resort to other means, such as, using holy water, searching for assistance from an NGO, dispersing siblings to relatives, and searching assistance from community based organizations, such as Iddir.

Findings from a Kenyan study conducted by Togom (2009) enlist a number of coping mechanisms. Orphan children, in their own words, described their way outs from their problems as follows:

> …’*leaving their ‘original’ living homes and lives due to abuses and stigma, seeking aid and assistance from institutions, relatives, community and parent’s friends, compromising education to seek for income generating activities, including the engagement in the risky behaviours or combining work with school of which the attendance often are interrupted or sometimes attending school during day time*

*and working at night. Compromising consumption and using their clothing, shoes and school materials by shifting with their siblings who are living in the same household.'*

With the emergency of the phenomenon of female child-headed households, there is a fundamental transformation of the family structure. With the traditional role of the extended family in caring for orphans threatened and weakened, children in female child-headed households are likely to live in poor conditions and have little chance of escaping poverty without external support. Their daring attempt to survive and continue as a family unit deserves attention and their capacity to do so must be strengthened as a matter of urgency. Such immediate and basic interventions as housing, feeding, educating and nurturing these children is both a moral imperative of every human being and essential to Africa's survival.

## 3.2 The Social Support Mechanisms: CBOs and Iddir

### 3.2.1 The Role of Civil Society to Promote the Wellbeing of Orphaned Households

As discussed by Loening-Voysey & Wilson (2001), community care strategies support informal, indigenous and traditional ways of caring for children in need of care, most commonly by extended family or kinship members.

This form of informal care is widespread and a practice acceptable in most cultures. However, increasingly, the capacity of families to take in orphans is diminishing. The assumption of community care is that communities have families, or, capable women,

who are willing and able to provide the care. This assumption is questionable. "While community care can certainly give individuals a better quality of life than they would have in an institution, community care can equally be a convenient cover for the neglect by the state" (Loening-Voysey & Wilson, 2001, p.25). Informal care has often been supported by strategies, such as home-based care projects, income generation projects for caregivers and community childcare committees. While these strategies bolster impoverished communities, they also serve to disguise the gaps left by duty bearers. In Ethiopia, such gaps are taken care of, sometimes, by Iddir as well as by some religious charities.

### 3.2.2 The Role of Child Focused NGOs to Promote the Wellbeing of Orphaned Households

The non-profit sector plays a pivotal role in providing services to children found in need of care. The care of FCHH has been provided almost entirely by non-governmental organizations (NGOs). Informal NGOs tend to be more closely aligned with the new developmental approach and rely more on donor funding than government subsidies (Loening-Voysey & Wilson (2001, p.22). In this regard, some NGOs including OSSA and FGAE, with funds from USAID as well as FHI, avail care and support services. Apart from this service, these NGOs avail nutritional support and attempt to link them to community-based organizations.

Citing various studies conducted in some African countries, Foster & Williamson (2000) asserted that there is a growing recognition of mobilising and strengthening community-based initiatives, such as, caring for the sick and orphans, to prevent the further spread

of HIV. Often, the groups best placed to strengthen family and community capacity are small grass-roots organisations, supported by non-governmental organisations. Community-based child support initiatives have a demonstrable ability to target small amounts of material support to large numbers of destitute orphan households.

## 3.3. Child Rights and Legal Guidelines

### 3.3.1 Review of Child Rights Declaration and Conventions

International convention implies that human development is the realization of a set of universally applicable, inalienable rights. It involves setting standards for the quality of life in any given context, and focuses on generic services and equity of access. Governments, through the ratification of the UNCRC, are obliged to respect, protect and fulfill these rights. The four guiding principles of the UNCRC are: 1) non-discrimination. 2) Maintain best interests of the child, 3) survival and development, and 4) participation (MoLSA and UNICEF 2005).

These four principles can serve to examine specific rights, such as the right to education, the right to benefit from an adequate standard of living, the right to protection in the absence of their families, and the right to the highest standard of health possible, including access to health services.

'Survival and development' is the basis for all other rights set out in the Convention. This refers not only to children's right to avoid infection with HIV, but also to economic and social policies that will enable them to survive their childhood and develop into happy and productive adults. The UNCRC reaffirms the position of the family as the provider of

guidance for children, and sees the state's responsibility as supporting the family in this role, rather than taking it over.

The rights of children have been denied by some kinds of bias – and bias is often a byproduct of projects that specifically target AIDS orphans for education or health care. This approach is discriminatory, as it excludes children outside the category from the services offered. 'In the best interests of the child' means putting children at the heart of program design, on an equal footing with the interests of adults, communities and governments. This has linkage to the right of children,, which means involving children directly in the design and evaluation of programs.

A child's right to protection has been embodied in many of the UNCRC's articles, (MoLSA and UNICEF 2005). For example, the right to protection from physical and mental abuse and from discrimination (Articles 2 and 19). The impacts of HIV/AIDS deprive children of their rights, for example, by removing them from parental care, separating them from their possessions and their families, and alienating them from their communities. The followings are among the many possible interventions that may protect children affected by HIV/AIDS: protecting the inheritance rights of women and children, protecting children from physical and sexual abuse, finding appropriate alternative care for orphans when members of the extended families cannot care for them.

### 3.3.2 Review of the International Documents

Article 14 of the Declaration of Commitment on HIV/AIDS of United Nations General Assembly Special Session on HIV/AIDS states: *"...gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS...* (WFP, 2006, p. 1)".

Another important dimension of gender and HIV and AIDS is gender-based violence (GBV) against women and girls and sometimes boys. WFP (2006) described GBV as pervasive in all societies and has serious implications for women, girls' and boys' ability to protect themselves from HIV infection. GBV and HIV /AIDS are inextricably linked and it is a serious human rights issue throughout the world. The United Nations General Assembly Declaration on the Elimination of Violence Against Women defined gender violence as *"Any act of gender-based violence that results in or is likely to result in physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life "*(WFP, 2006, p.9).

### 3.3.3 The African Charter on Child Rights

The African Charter on the Rights and Welfare of the Child defines a child as a person below the age of 18 years (Article 2 of ACRWC2002. A number of articles articulate various entitlements related to children in ACRWC. For example, Article 27 states that Children should be protected from all forms of sexual exploitation and sexual abuse. On the other r hand, the right of every child to an education is contained in Article 11: This

article also elaborates that such education to include the preservation and strengthening of positive African morals, traditional values and cultures. Article 11 of the ACRWC further specifies the State's obligation towards the education of girls particularly articulating: "*Governments should also take special measures in respect of female, gifted and disadvantaged children, to ensure equal access to education for all sections of the community*".

Another article of the charter provides some latitude of choice for a child to opt for one of the available forms of orphan care. *The African Charter on the Rights and Welfare of Children* states that it will ensure that any child, who is parentless or temporarily or permanently deprived of his/her family environment, shall be provided with alternative family care, which includes foster placements or placement in suitable institutions for care of children (Article 25[2]). This will be done only if the children are willing (MoLSA 2005).

### 3.3.4 Review of Ethiopian Laws and Policies Regarding Children

According to a review conducted by Save the Children- UK (2007), Ethiopia has ratified two key international instruments covering the care and protection of children including FCHHs. These are the UN Convention on the Rights of the Child (UNCRC) and the African Charter on the Rights and Welfare of the Child (ACRWC). The UNCRC had been ratified by Ethiopia in May 1991 while the African Charter on the Rights and Welfare of the Child was ratified in 2002.

In addition, FCHH are protected under the domestic legislative and policy documents, such as, Civil Code of Ethiopia (1960),The Education and Training Policy (1994),Social Development and Welfare Policy (1996), Health Sector Development Program and Financing Strategy (1998), Revised Family Code of Ethiopia (2000), Revised Penal Code (2004), National Action Plan on Sexual Abuse and Exploitation of Children (2005) and National Plan of Action for Orphans and Vulnerable Children (2004-2006, expired).

According to a review by Seyoum & Aman (2007), Article 627 of the Revised Penal Code prescribes imprisonment ranging from 13 years to 25 years on a man guilty of inducing a child below the age of 13 to engage in sexual activities. The penalty for a woman who commits exactly the same offence is imprisonment for a maximum of ten years. The sentence will be up to 15 years of rigorous imprisonment where the induced child is between the age of 13 and 18 as per Article 626 of the Code. Articles 635-8 of the Revised Penal Code also penalize trafficking children for prostitution and sexual exploitation. Ethiopia has laws that comply with the Convention requirements. Citing some local studies that showed the existence of child prostitutes, Seyoum & Aman (2007) argues that the reality on the ground is different though. According to them, what worsens the tragedy is that some of them started prostituting at the age of 9. This is a staggering problem given the HIV/ AIDS pandemic, which is raging.

Existing legislation protecting children has been held in a number of legal and policy documents and, as such, few government officials, service providers or community leaders have a comprehensive understanding of the measures protecting children. Effort needs to be exerted to compile these provisions into a readable and usable format (Save the Children UK, 2007, p.2).

The law should promote equality and prohibit discrimination in access to rights and services in education and health care, in protecting children from abuse and exploitation from harmful practices (such as exploitative child labor and some harmful traditional/cultural practices). It should also protect their rights to inheritance, promote appropriate models of alternative care for children without adequate family care, and define roles and responsibilities of duty bearers.

Art 7(1) of CRC, Art 36(2) of the constitution of the Federal Democratic Republic of Ethiopia, for example, recognizes the right of every child to life, a name, and nationality, parents or legal guardians, and protection from exploitative practices that may be hazardous or harmful to his or her education, health, or well-being. *The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality, and, as far as possible, the right to know and be cared for by his or her parents* (Smart, 2003, p.15).

According to the Ministry of Women, Children and Youth Affairs (MoWCYA), a vulnerable child is one 'whose survival, care, protection or development might have been jeopardized due to a particular condition, and who is found in a situation that precludes the fulfillment of his or her rights.

333The Ethiopian Constitution, in line with international and regional conventions on the rights of the child and the elimination of all forms of discrimination against women,

stresses the responsibility of the state to provide special protection for different categories of such children. This includes victims of violence, abuse, trafficking, child labor and harmful practices such as female genital mutilation and early marriage. It also encompasses children who are living with disabilities, in conflict with the law, children working and living on the street, or victims of commercial sexual exploitation. It makes specific reference to the protection needs of children in emergencies. The 1996 Developmental Social Welfare Policy of Ethiopia spells out the government's commitment to the causes of children. It has also covered all issues related to child welfare and the issue of HIV/ AIDS affecting children (Seyoum & Aman, 2007).

However, Smart (2003) reflected that having a good legislative framework does not automatically translate into benefits for children. In fact, some of the conventions that our country has ratified, for example, UNCRC, have not yet been endorsed. Such treaties would have been better legally binding if published in the Federal Negarrit Gazette, the state's newspaper where national proclamations are announced to the public at large. In addition, there is a need to identify gaps through research so that the instruments will effectively be implemented.

# CHAPTER FOUR: METHODOLOGY OF THE STUDY

## 4.1 Study Design

This qualitative study is explanatory as well as descriptive. Using mainly the qualitative technique of case anecdote, it tries to narrate the situations of household heading female FCHHs impacted by HIV/AIDS. It is also explanatory as it tries to examine the psychosocial experiences, challenges and opportunities of female child-headed households based on selected theories from gender and rights perspectives. The age range of the case study participants was between 12 to 17 years. Purposive to the scope of the study, the delimitation of the age of the sample was believed to allow the researcher to be able to look at each participant's story in depth and holistically.

### 4.1.1 Study Area:

The study area is Adama town 100 kilometers east of Addis Ababa, the capital city of Ethiopia. . The town is one of the significant corridors along the Ethio-Djibouti main trade route. For many years, the town has been one of high HIV prevalent areas. Adama attracts large influx of people especially during weekends for entertainment

### 4.1.2 Participants:

Extensive work was involved prior to the fieldwork to identify participants for the study., Letters were sent out to the town's municipality, HAPCO, and Social Affairs department offices, requesting their cooperation. In addition, the town's comprehensive Iddir umbrella organization, OSSA, and Medan Act were contacted. A local fieldworker was recruited through contacts at the Family Guidance Association of Ethiopia youth center.

The fieldworker, who was familiar with the local communities and had prior experience in field research, followed up with the contacted organizations to arrange an interview schedule.

## *4.2 Method of Data Collection*

The study mainly employed the case-study approach supplemented by key informant interviews and focus group discussions. Three data collection instruments were prepared to this effect. Data collection began on October 11 and lasted until December 19, 2012.

### 4.2.1 Semi-structured Interview

For the case study, a qualitative semi-structured interview had been applied, containing 17 main items with a total of 21 sub-items. Interviews for the **Case Studies** had been conducted in their place of residence.. Of the 12 selected cases envisaged, two had defaulted either for not consenting or for poor communication, and ending up with 10 interviews with primary study participants. Interviews was carried out in five consecutive days, two cases per day. The language preferred by the respondents was Amharic, lingua franca of the nation Most individual interviews took 45 minutes in duration, on average. The researcher used one assistant female nurse for the interview. The selection of same sex interviewer was purposeful to elicit detailed and open responses.

### 4.2.2 Key Informant Interview

**Key Informant Interviews (KIIs):** The KIIs contain 7 open- ended items. The interview to KIIs had been conducted at their workplace. Five Key Informants were selected

from among HIV/AIDS experts of HAPCO office, official of the Social & Labor Affairs department, and staff members of NGOs. The interviews took between 20 to 30 minutes. The principal researcher independently undertook the KIIs.

### 4.2.3 Focus Group Discussion

**Focus Group Discussions (FGDs):** A discussion guide consisting of 7 issues was designed for the FGD. The FGDs were conducted in two places one at kebele 19 office and the other at FGAE youth center. Focus Group Discussion took about 60 minutes each. Three-research team including the researcher conducted the FGD. While the principal researcher leads the discussion, one assistant (the female nurse) moderates, and another assistant (the field worker) takes written notes. Prior to the conduct of the FGDs, both assistants were oriented on the research questions, the FGD guides questions, the FGD guide and the ethical, as well as, research protocols of a qualitative study.

The discussion was on the impacts of HIV/AIDS in Female-child headed houses and issues related to illnesses and deaths in households in their communities. Questions about household structure and activities, community support, the roles of Iddir, and any interventions by relevant Government sectors and NGOs were raised. The FGD were asked additional questions about child rights issues related to child labor, gender-based violence, girls education, and legal protection Further, they were asked to describe the emotional and personal situations of the children heading the household and how these children are trying to cope with grief, stress, economic hardship, and AIDS related stigma.

## 4.3 Sampling Technique

The participants were female child-headed households who lost one or both parents to HIV/AIDS and who are shouldering household burdens in one way or the other. This particular criterion was set in order to adhere to the objectives of the study. The age margin of the participants is pertinent on two grounds. The maximum age meets the definition of a child while the minimum age is the lowest margin in line with WHO's classification of youth age which is said to be 10 to 24 years. Hence, the age group from 10 to 17 years encompasses both a growing child entitled with child rights and girls who are embarking on pubescent changes and some of them in the verge of experiencing identity crisis in their transition to adulthood. The decision not to include children below 10 years is in order to get comprehensive data of the problem under study.

According to CSA (2007), the population of Adama town, the research location , is estimated to have more than 200,000 people with female population exceeding by 1.5 percent. There are around 59,432 households somehow scattered in the 22-kebele administrative areas. Female-headed households account for 52.5 percent of the total female-child headed households.

In order to select the subjects under study a systematic random sampling method was employed. . As a first step, the list of Female-child headed households affected by HIV/AIDS obtained from HAPCO, Social & Labor Affairs offices or NGOs like OSSA and FGAE, who avail care and support services. According to an official report by PEPFAR/USAID (2008), the city of Adama houses 101 Female-child headed households.

Out of this, 11 eligible households were selected, representing 10 percent of the total estimated female-headed households. Of these, one defaulted for not consenting to participate in the study.

### 4.4. Ethical Consideration

Confidentiality and respect to the participant's privacy, confidentiality and respect has been protected, as well as, her identity, throughout the study. In adhering to this principle, pseudo-names were given to the participants of the case study. This was especially important because the nature of the study deals with sensitive issues around HIV/AIDS.

Participation was voluntary. After the researcher had explained the purpose and objectives of the research, verbal consent was solicited from all participants by reading written declaration of statement.

### 4.5 Analysis Strategy

The analysis strategy adopted in this research was interpretative phenomenological analysis (IPA). Interpretative phenomenological analysis is a relatively recent qualitative methodology developed specifically for psychological studies. According to Smith & Osborn (2004), interpretative phenomenological analysis recognizes that different people perceive the world in very different ways, dependent on their personalities, prior life experiences and motivations. It attempts to explore/understand/make sense of the subjective meanings of events/experiences/states of the individual participants themselves.

As described by Smith & Osborn (2004), IPA is strongly influenced by phenomenology, a term used for a range of psychological approaches concerned with subjective experience, which in turn developed out of Husserl's philosophical phenomenology. While IPA is committed to the value of attempting to understand the world from the perspective of one's participants, it recognizes that this cannot be done without interpretative work by the researcher who is trying to make sense of what the participant is saying. This explains the interpretative part in the methodology.

IPA is an idiographic approach. It begins with the detailed analysis of case studies and cautiously move to more general statements about groups of individuals. IPA studies are usually conducted with small numbers of participants (e.g. six to fifteen) because the aim is to present an intimate portrayal of individual experience. "IPA … is very interested in cognitive and emotional entities and, when an IPA researcher is looking at what a person is saying or writing, the researcher is concerned with trying to find out what that person thinks and feels about what they are talking about" (Smith, J.A. & Osborn, M. 2004, p.230.

The full narration of the case studies in this research are shown in the Annex part of the report of the study. Anecdotal summaries of each case are presented in the Results section. The case studies were coded to generate the main theme and the sub-thematic areas. Excerpts were drawn as necessary from the case studies in presenting the results. During analysis, cross-cases were mentioned when they portray issues fitting under the

same category of themes. The responses of FGD participants were immediately transcribed with fresh memory, and the recorded observations from key informants were described in the results section.

The assessment of the triangulation was made possible by using the different data sources, including case studies , FGDs, and KIIs.. . Triangulation is the use of a mix of methods, sources, information and/or researchers to acquire different perspectives on a situation. This increases the trustworthiness of information generated in research.

The report of the present study follows a linear-analytic structure as per Gray who suggests that "if…. the final case study report is being written for a largely academic audience, then the linear-analytic structure would probably be acceptable, since its format would be readily recognized by academics (Gray, 2004, p.145)." The written format also adheres to Gray's rationale of cross-case analysis and the result presentation type is called multiple case study reporting. In this type of reporting, Gray (2004) argues that the main body of the report could begin with narrative descriptions of each of the case studies, but this can be bulky and could be confined to the appendices. In this case, the main body of the report would consist of the analysis and supporting data of the cross-cases.

# CHAPTER FIVE: DATA ANALYSIS, INTERPRETATION AND FINDINGS

## 5.1 Introduction

This chapter presents the data analysis, interpretation and the findings of the study. The findings emanate from both the analysis of the transcripts as well as from field notes made during the interviews. The findings have been grouped into sub-themes, which are supported by materials from the text and interpretative write-up. The data analysis will be discussed before providing the findings of the study.

## 5.2 Data Analysis and Interpretation

### 5.2.1 Characteristics of Participants of the Study

The age of respondents ranged from 12 to 17 with a mean age of 15.3 years. In fact, some of these female children had been infected with HIV/AIDS as young as 10 years of age. orphan, they faced the responsibility of providing care to one or both of their sick parents (Table 1).

**Table 1: Characteristics of the case studies**

| Case # | Age in years | HH Size | Grade | Educational status | Status of Orphanage |
|---|---|---|---|---|---|
| **Case 1** | 16 | 4 | 9 | Couldn’t continue | Single orphan |
| **Case 2** | 17 | 3 | 12 | Dropped out | Single orphan |

| | | | | | |
|---|---|---|---|---|---|
| **Case 3** | 14 | 3 | 6 | Repeating | Double orphan |
| **Case 4** | 15 | 4 | 8 | Dropped out | Single orphan |
| **Case 5** | 16 | 2 | 11 | Discontinued | Single orphan |
| **Case 6** | 15 | 4 | 10 | Couldn't continue | Single orphan |
| **Case 7** | 17 | 3 | 12 | Going college hampered | Double orphan |
| **Case 8** | 16 | 5 | 10 | Started diploma | Double orphan |
| **Case 9** | 14 | 2 | 7 | Attending hardly | Single orphan |
| **Case 10** | 13 | 4 | 5 | Repeating | Double orphan |

Source: Own survey

It is clear from the data that six were single orphaned while four of the cases the children were double orphaned. Young girls assume headship of their respective households after the parents are dead or separated following family disintegration (Table 1).

The size of the households was 3.4 on average (a minimum of 2 and a maximum of 5 household members). One of the immediate problems of HIV/AIDS was the situation of education of the girls, as well as, her siblings. Among participants of the case study, the least grade level of the girls was grade 5 while the highest was grade 12 complete. However, very few are trying to attend class session, whereas, most of them were either dropped-out or failed to continue after certain grade level (Appendix-4).

With regard to Key Informants, each individual represented one entity, such as, a Government office or an NGO working on HIV/AIDS. There were three females among

the five key informants interviewed. The information gained from these key personalities was important in further probing some issues that remained unclear (Table 2).

**Table 2: Characteristics of key informants of the study**

| Informant # by Organization | Sex / Age in years | Job Position |
|---|---|---|
| Informant 1/ FGAE | Female / 39 yrs | Head nurse, Palliative Care Clinic |
| Informant 2/ HAPCO | Male / 33 yrs | HIV/AIDS expert, Adama town |
| Informant 3/ Labor & Social Affairs | Female / 41 yrs | Family & Child affairs expert |
| Informant 4/ OSSA | Male / 29yrs | HIV Prevention specialist |
| Informant 5/ Save the Children | Female / 27yrs | Focal person, FCHH project |

The discussants of FGDs were grouped into two groups based on some similarities in order to maintain homogeneity at a certain level. Hence, participants representing pertinent government sector offices were in group one while stakeholders who are closer to the female child-headed households, in terms of direct social network or support, were part of group two. The size of both groups was equivalent. Of the total FGD participants, 59% were females. The age of discussants ranged from 25 to 41 years with mean age of FGD-1 and FGD-2 were 32.2 and 28.7 years, respectively (Table 3).

The officials from HAPCO and Adama town municipality have acknowledged the growing number of orphans since the advent of the impact of HIV/AIDS. Other discussants mentioned specific instances of the problems of children affected by the pandemic.

A participant from Women Association pointed out the staggering means of livelihood while those representing Women office and Iddir cited the huge household burdens shouldered by the female child as a headship. NGO staff, as well as, an expert from MoLSA expressed the innumerable effects of AIDS, promoting orphanage resulting in dropping out of school, and violation of rights, including sexual exploitation.

**Table 3: Characteristics of FGD participants**

| Description | FGD-1 | FGD-2 | Total # of FGD Participants |
|---|---|---|---|
| Group size | 9 | 8 | 17 |
| Number of discussants by sex | Females=5<br>Males=4 | Females=5<br>Males=3 | Females=10<br>Males=7 |

| Age range in years | 28-41 | 25-36 | 25-41 |
|---|---|---|---|
| Mean age | 32.2 years | 28.7 years | 30.0 years |
| Representation | HAPCO, Labor & Social Affairs office, Women office, Municipality, Justice, Police, and Kebele Administration | HBCGs, NGO staff, PLHA Association, Women Iddir Association, and Faith-based volunteers | |

Most participants in FGD-1 session stressed the vulnerability of the young girls who assume parental roles due to death of both parents. In addition, the FGD revealed some other interesting accounts facing the female child. They had reported the problem of property snatching from the victims by some relatives or acquaintances. It was evident that such individuals tend to rob the properties by claiming in lieu of unpaid loan given to parents of the orphan. Many participants of the FGDs also mentioned cases of inheritance issue following the death of parents. Information on the challenges of care and associated emotional problems emerged from FGD-2 discussants.

### 5.2.2 Thematic Coding

**i) Central Theme**

The female child heading a family in AIDS stricken households enumerate stories of overwhelming responsibilities. While trying to survive depression emanating from chronic stress, the young girl was stumbling to sustain livelihood, overstretched with domestic chores and provision of care. Such challenges were not merely the consequences of the impact of HIV/AIDS rather they were encapsulated by societal expectations of traditional gender roles. In this context, the girl child is compelled to discontinue attending school to execute the roles as household headship as it became a multiple and demanding. In search of finding means of income, many of the young girls were prompted to engage in risky ventures. This includes transactional or commercial sex work in which they are likely to be abused, thus eventually prone to the risk of HIV, including unintended pregnancy and other sexually transmitted infections (STIs). On the other hand, the young girl has to adjust to pubertal changes such as menarche, the first menstrual blood, as well as the developmental task of transiting from child to adulthood. Indeed, these orphaned and vulnerable children try to cope with enormous psychosocial and developmental challenges by themselves. The Female-child headed households may get support from the community and NGOs doing care and support interventions. Yet, such supports are sporadic, short-lived, and not comprehensive to address the gaps facing the young girl and the needs of Female-child headed households impacted by the pandemic.

**ii) Themes by Sub-categories**

Following the identification of the main theme, the case studies were further elaborated to determine the most prominent themes and categories. Thus, it was classified into

seven independent themes with 29 sub-categories. The information was then tabulated by checking every case to help in the cross-case analysis of the study (Annex 1).

## 5.3 Findings of the Study

The present study revealed that care giving is associated with early responsibility. In fact, the children started care giving at a very young age. Many of the study participants assumed care-giving responsibility when they were, on average, 12 years (with a range of 10 to 14 years). Obviously, one or both of their parents had been sick for a few years before they die and at the time before the girls turn out to be in their teens. In this regard, except Case #2, Case #5, and Case #7, the remaining seven interviewees have started care provision before they were 13 years of age. r To some of the female children interviewed, care giving has been an experience gone with the deceased. For a few of them, it is both a recent past and a continued responsibility. In the following sub-sections, the study provides the findings of the study related to taking the role of parenting, perception, leadership strategy, challenges of care and coping.

### 5.3.1 Being Head of a Household: Assuming Parental Responsibilities

AIDS orphaned female child headed households were generally in the brink of transition to adulthood with a gap in parental guidance. The coming of age is not in normal transgression because when they are about to complete childhood most start to assume parental roles as they embark on puberty eventually. The pubertal changes bring developmental milestones that in turn become the concern and confusion of the young girl emerging from a household struck by the pandemic.

One of the apparent issues at this age for the female householder is menarche, seeing the first menstrual cycle. Apart from confusion on how to manage her sanitation, the young girl is worried about its meaning to her body. A significant number of young girls are devoid of skills to keep cool to this particular experience. To some, the experience is sudden and leaves the adolescent girl amid worries and depression. In this regard, case # 1 discloses the following:

> *"The growth of my breast and sign of my menstrual blood were both sources of mockery from male adults. They say you are now a lady, like that."*

Case #2 has resorted to attend a night school after being frustrated at her menstrual blood spilled over her classroom chair.

> *"Many times, I am scared. I suspect that people here and there seem to talk about our family. The feeling of being orphaned compels me to stay distant from my peers. Even if they request to join them, I hesitate to go with them creating some excuses. Yet, I feel lonely though none of them has actually rejected me."*

Similar feeling of remorse happens to Case #3, who rather attributes the catastrophe to God's punishment. In order to reduce her despair, she said, she resorts to prayers for an extended time besides crying.

> *"I strive to execute all my responsibilities because, after all, I accept my headship role as a social ascription bestowed upon me. In fact,*

*doing so is a question of morality. Yet, as a youngster, I feel pity for not able to go along with friends of my age. I question to myself: Am I becoming older than my age mates are because I have replaced the roles of my deceased parents? At the end of the day, however, I have no answer except experiencing an unpleasant emotion."*

The following extracts depict responses of participants of the case study when they were asked to describe what it means for them assuming parental responsibilities. Concerning the issue, case #5 describes the following:

*"I feel that my childhood has been taken away from me. I am now not only a child anymore but also both a child and a mentor at the same time. I now have to adjust from the things that I used to do before like going out to have fun. If I go out, who will look after my siblings? I have to look after them. I have to ensure that they are well and that they have food to eat. Do you think that children with parents and at my age level do the same activity that I do currently? I do not think so. Children at my age want to do their own business like going to school, playing with friends, sharing information about transition biological needs and so on."*

Case # 7 had something similar to say when the same question was posed to her:

*"Being responsible at home is tough. You know there are things that you can do... I am only human. I am still a child after all. I steel want to*

*be like other teenagers. Before I found myself performing this role, I was not thinking about getting food, doing washing or things like that. You do not even think about enjoying, looking for future partner as children of your age because you constantly have to think about the situation at home. As a female child, I have my own biological problems like adjusting changes that happen during transition to adolescence. I have no one to share such issues with."*

Both extracts present very strong views and feelings on assuming parental responsibilities. The situation clearly disclosed the impact of HIV/AIDS pandemic on female child-headed households with regard to handling responsibilities of taking care of children and fulfilling the needs of the families following the death of their parent(s).

What transpired in these instances is how the particular respondents involved have resigned to the reality. . The situation is considered as a fate or pre-destined, as case # 4 demonstrated below:

*"I have accepted this as my fate. Maybe, I am the sort of person that must struggle through life in-order to succeed. I think this is what God has given to me that I must struggle in order to live. By now, I have come to accept it. I trust in God that He always support the weak people."*

As expressed by case #4, acceptance is the rule if the household responsibility as something that one could not possibly escape, and by understanding not only the fact that children she is supposed to care for are her siblings, but also by the circumstances that have precipitated it.

When asked to share her feelings and thoughts towards carrying responsibility for households and looking after her siblings, case #10 responded as follows:

> *"I have been involved in it. Therefore, by now, I do not see anything wrong with it. My mother had been sick for longer time before she died. So right from the beginning I had to look after her. After my mother died, though most of the load fell on me, my siblings share some activities with me. Therefore, I do not know-I cannot say I see anything wrong with it. Well it is wrong that I have to look after children, as I am a child too. However, after all, they are my siblings; and nothing that I can do about it."*

One can easily understand from the above response that though the female child headed household feels that, as a 15-year-old, she should not have to look after children and be responsible for a household, the situations have given her no choice.

To conclude, the findings seem to portray the type of challenges and psychosocial needs that the female child headed households interviewed in this study confront. The findings also show the effect that these challenges and psychosocial needs have on their perceptions of the situation that they find themselves in. Obviously, having to carry the

burden of responsibility for a household as a young person is so difficult. These children face a number of challenges at a social, economic, biological and emotional level.

### 5.3.2 Perception of Female Child as Head of Household

Many of the case study participants are apprehensive of being in a headship position. At the beginning , they were not clear about the role of being a head of a household. In fact, most do not know the criteria by which individuals are designated the head of the household. It is uncertain whether such designations are given on the grounds of moral authority, earnings, decision-making or presence in the home and responsibility for day-to-day household functions.

> *"Life is difficult as a woman. You suffer a lot due to your sex. For instance, I have a brother, my twin. The consequences of AIDS accumulate on me as compared to him. Even though I am assuming the headship, handling siblings is the most challenging task. It is only my younger sister who obeys me and willing to share with me the burdens of domestic chores" (case#1).*

The girl children participating in the case histories in this study have mixed perception regarding household headship. Case # 6 says:

> *"At the start, I expected it was only looking after children but later on I know it is all about the economy and handling the discipline of siblings as well as replacing the role of parents."*

Some others have a different perception of becoming a household head. Case #1 and Case #9 have negative psychological feeling associated with heading a family impacted by HIV/AIDS. Both questioned if they are feeling old, when they are referred as "mom" by their younger siblings. By contrast, a few others considered it a blessing by attaching some positive values for taking care of the surviving family.

In particular, Case #3 exalts the virtue of her headship roles both on religious and moral grounds as described below:

> *"When I started giving care to my father, I was frustrated especially after I knew he had the virus. Once I was accustomed to that, my fear changes to grief realizing his eminent death. Soon misery said to have gone, and then another chapter begins when I became entirely the head of our household. I felt neither bad nor good to get into this. I think it is human to care for others: a question of morality and partly from my religious teachings."*

### 5.3.3 Leadership Strategy of Female Child as Head of Household

Participants in the case study were asked to respond to the question on their leadership capacity as female child-headed households. The question was specifically focused on understanding the division of roles and maintaining discipline in the household.

In relation to division of roles in the household, the lead girl assume the responsibility of most of the housework while delegating the remaining work to their siblings according to age. Concerning leadership, case # 5 describes as follows:

> *"I would not declare whatever hectic situations I am in as head of the surviving household with younger and demanding siblings. Parental loss is not an easy experience. It is family breakdown. For example, it has been three months since one of my younger brothers left home. He says he is working as 'woyalla' or coolie. Now he has dropped out of school. Apart from this, he appears home very rarely. His situation remains my continued embarrassment. I am afraid of the fact that he turns out to be a street boy like this. It is miserable. As I think about his separation from us, I get betrayed because it seems I am not able to control them or I don't know, perhaps I am not meeting their basic needs."*

As stated above, the role of leading and managing domestic activities and handling younger siblings has been challenging for the female child-headed households.

Likewise, case # 8 expresses her experience of leadership following the death of her parents in the following way:

> *"It is not an easy task for a young woman like me to lead a family with multifaceted problems. However, I have convinced myself that I could manage and support my siblings whose parents left behind. I usually take most of the activities for myself. When needed, I divide some the works to my siblings. The way I divide the work at home is that I make sure that all the work I have assigned them to perform has been done well and nobody should be complaining. 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 manage the home."*

### 5.3.4 Challenges of Care Giving as Head of Household

This particular issue deals with the most pressing challenges of carrying the responsibility of running a household as young female headed household in the context of other competing demands on time, i.e. the pressure of juggling and managing multiple responsibilities. Having to deal with the social pressures confronted by siblings complicates matters even further. The challenges they face are exacerbated by the fact that the female child-headed households are young and have their own individual concerns and difficulties.

The following extracts highlight perceptions of participants of case studies concerning the most pressing challenges and feelings. .

Concerning the issue, case # 8 had this to say:

> *"The worst side of being a female child- headed household for a young girl like me is handling different concerns at the same time. What I am saying is that you cannot be a mother, a father, a student, a sister, a girl who love to establish a partner and so on at the same time. As a diploma student, I have to go school and most of the times when I come back from school, I have my own books and home works to do. Yet, when my siblings need something, I have to handle that as well. I cannot say this or that person will manage that everything falls on my shoulder."*

Providing care is not a simple matter. It has its own concomitant effects influencing the life of the young girl. In the first instance, it is apparently a concern over the health of the young child. The female child-headed household child tries to cater care with little knowledge or skill. The following excerpt, taken from responses of Case # 10, illustrates such health threat:

> *"Care giving is stressful, not merely for helping them [the sick parents] eat, take medicine and use the toilet, but beyond this assistance, care giving involves providing emotional support. On top of this, sometimes, you get contaminated with their body fluids. I*

*pray to St Mary to save me because I do not have the required skills to provide care. I fear that I might catch HIV."*

For others, the challenge is an increased workload. As described by Foster & Williamson (2000), when a parent develops HIV related symptoms, children often shoulder new responsibilities. These include domestic chores, such as cooking, cleaning, carrying water and laundry, care giving activities such as feeding, bathing, toileting, giving medication and accompanying relatives for treatment, agricultural or income generating activities and childcare duties. This workload indeed transcends to more aspects of the growing child, such as education and then future career.

Some of the participants of case studies elaborated the burden of caring emotionally when the sick parents become terminally ill. Case # 2 gave a detailed account of her challenges as follows:

*"The period was hard to explain... it was hard! I lost my parents when I was fourteen years old. I began to take care of my sick mother alone when my father left home after realizing that my mother was sick of HIV/AIDS. Before she got seriously sick, she used to do everything alone, including her work as waiter. Since then, I had to look after her (my mother), two siblings as well as my grandmother. In the mean time, my mother was very ill and gave-up working as waitress- the only means of earning income for the whole family. I had to create income for the family and to be with my mother*

*because she always wanted me next to her all the time. Her situation together with the responsibility of taking care of my siblings and my grandmother forced me to withdraw my preparatory school. When my mother died, I had to arrange a funeral ceremony with limited support from distant relatives. Following the death of my mother, we were not able to stay together as my elder brother went away to distant location. I ended up living with my younger brother and the aging grandma. After I lost my mother, I encountered very difficult life, including sexual abuse from a man who seemed to become supportive to me."*

Some of them reported that they were confounded by the question of identity, compounded by the loss of parental guidance, developmental task of transition to adulthood and the prevailing social stigma. In expressing her feeling, case # 5 describes her situation as follows:

*"I feel that I have been at the crossroad of handling parental roles while at the same time embarking on the developmental task of transition to adulthood. On top of all, I face difficulty over adjusting myself with such pubertal changes as menarche is eminent during the period of adolescence. I usually worry about the need to belong to a heterosexual peer while I am always busy doing domestic activities."*

According to both FGD and key informants, the female child who usually happens to be the primary caregiver, had taken time off from informal employment or schooling to take care of the siblings and meeting their basic needs. As to the key informants, the burdens of household care giving add to the loss of household income and attaining the biological and psychological needs are the most challenging experiences of the female child headed household.

### 5.3.5 Strategies for Coping as Female child-headed Household

With regard to strategies for coping with the challenges of being orphan and taking responsibilities of head of household, the study identified different mechanisms. Participants of the case studies reported that they had used different strategies to make them free from grief, pain and problems they faced following the death of their parents. 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. Case # 5 stated that she prayed when she started feeling bad and she felt much better and calmer after prayer.

Case #8 , who lost both parents in one day, has reported her experiences as follows:.

> *"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. Moreover, 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 someday. They used to encourage me and I 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. In support of being friend of orphan children as coping mechanism, case # 9 had the following to say:

*"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 every day. She tells me that I should pray before I go to sleep so that I do not think about my parents so much. I find praying helps me a lot."*

According to the study of Foster & Williamson (2000), increased domestic workload is often disproportionately greater on girls than boys. In order to generate an income, adolescents may leave orphan households to seek work in towns as agricultural and domestic labourers. Some girls become involved in commercial sex or enter into

marriage as girl brides in order to provide the needs of younger children in their household. Other coping mechanisms attempted by orphans include, seeking relief aid from family, friends and neighbours is a common response to economic crises, resulting from disasters (Foster & Williamson, 2000, p.8). The young girls, who restlessly try to get relieved from the mounting problems they experience, especially to ensure livelihood, uses various forms of coping responses Concerning this, case # 6 had this to say:

> *"What I should do to make food available is that I tend to find someone to help me meet the needs of my surviving family members including me. Otherwise, left with no alternative, I think of engaging in a risky sexual relationship. I feel disguised to speak about that. It is a reality facing me. My body is a giveaway for money at times. Indeed, without my internal will, against my faith, otherwise who cares? I am worrying if this is going to be my final fate."*

Such a risky mechanism was corroborated by a relatively recent study. With limited or no education, external support and no means to generate income to provide for their siblings and out of desperation, a number of orphan girls end up as prostitutes or get married at a very early age, often to too much older men( Togomo 2009, p.30).

A significant number of FGD discussants in the present study confirmed the existence of child prostitutions from households affected by the pandemic. On a similar account, key informants invariably described most teenage girls heading a household engage in

transactional sexual relationships, desperately or coerced to do so, thus, eventually becoming vulnerable to HIV.

### 5.3.6 Views on the Future as Female child Headed Household

In Frieze & Yu Li (2010), Eagly argued that because the traditional women's or feminine role encompasses the idea of caring for others, especially those within the family, it is not surprising that women tend to be seen by others as more helpful, kind, and devoted to other people. The same source mentioned studies, which have consistently shown that women provide more caring to children in the home, as well as, to elder lies and to other family members who need assistance. In responding to the question concerning their future, most of the case study respondents 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. To present a few of such responses, as an example, case # 4, case # 6, and case # 8 expressed their future perception in the following way:

> *"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'' (case # 4).*

> *"I do not have anyone to advise me or who can assist me keeping the young siblings or me. I have remained together with my siblings alone. We will continue keeping ourselves; God is with us" (case # 6).*

*"As for me, I do not expect any of my relatives to help in the future; we have been alone, because they failed to help us since the death of my parents. Now that I am so much older, I can take care of my siblings" (case # 8).*

To sum up, the study briefly presented the main themes of the stories/reflections of the child household heads on the roles and challenges of household care giving efforts. In the following section, the stories/reflections of their siblings gathered from the focus group discussion (FGD).

## 5.4 Perceptions of Siblings of Female Child-headed Households

In addition to the face-to-face interview with the selected female child -headed households in the study, discussion with focus group composed of siblings of the female child household heads was held in order to understand the nature of the relationship and hierarchy existed in the household. It includes the relationship between brothers and sisters and the 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 participated in the first round while 2 boys and 3 girls in the second round, all drawn from the selected child household heads. 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

### 5.4.1 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 neighbors and friends) had sympathy towards orphan children. They have often been supported with food and other educational materials, such as exercise books by neighbors and friends. This indicates that the community response to the needs of orphan children was not only promising but also reflects a level of acceptance of these children after the death of their parents.

Despite support from neighbors and friends, however, almost all 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:

> *"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 me education and other support when she took me to her home. However, I found myself as a house cleaner in her house and I did all the housework. I baked "Injera". I washed clothes etc. Her husband*

*always annoys me. If my mother was alive-----" (kept silent for long and discontinued her reflection).*

This contasting behavior between relatives and neighbors 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.

Respondents were asked if they have any social networks such as Iddir, Iqqub and Mahber (civic associations) that could be used as a coping mechanism. The majority of the respondents replied that they do not have any kind of social networks currently.

### 5.4.2 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. In addition, one participant was uncomfortable to reflect on the issue. The reflections of some of the children, among the remaining FGD participants, on the issue vary. In reflecting her perceptions, one of the FGD participants uttered as follows:

> *"I do not feel nice about the death of my parents. I find that my friends with both parents alive celebrate their birthday, their parents buy them presents. Now with me, my parents are not there to buy me any present.I feel depressed."*

The reflections above demonstrate that life for most children in FGD has changed since the death of their parents. They experienced lack of basic human needs since the death of their parents. Participants (female child household heads) in the study also demonstrated the decline in the standard of living in their households after the death of their parents. 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.

### 5.4.3 Perceptions of Siblings towards Existing Care Taker (Female Child-headed Household)

Elderlies or their sisters of the siblings were taking care of their daily life. . The siblings expressed that a specific sibling assumed parental responsibilities since the illness of their parents and thereafter the death of their parents.

Though living in abject poverty, the perceptions/attitudes of siblings towards their existing caretakers were generally positive. In expressing her perception towards her caregiver, one of the FGD participants states the following:

> *"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 to assure our survival."*

In addition, another participant stated that his sister is the one who give all she has for the betterment of her siblings. Concerning his care-giving sibling, he has the following to say:

> *"Before the death of our parents, my sister used to be good at her education. She dropped out of school following the death of my mother and does casual work now so that I and two of my sisters are able to continue with our education. I always sympathize deeply with her soft-heartedness to support us since the death of our parents. I promised myself to be successful in my education and to change her life."*

These reflections serve as evidence for not only of 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.

### 5.4.4 Day-to-Day Challenges: Problems versus Perceived Needs

A number of participants in the FGD, as well as, some key informants identify such necessities as food and clothes to be basic needs to be fulfilled. However, a few young girls heading households reported that the younger siblings themselves mentioned education, food and materials as part of their major needs.  Some key informants cites statements like "*Not knowing what to eat tomorrow makes some siblings more worried and disturbs my sleep"* and "*I am worried about the future because I cannot go to school, I have no money. My parents used to pay my school fees. Education is so important"* – were quite common and showed that their lives were difficult and marked by immediate

and future challenges. Some adults confirmed this by saying that *"these children do not have food. They spend most of their time working in the villages to get something to eat."*

> *"As an orphan, you are affected by the deep-rooted feeling of bereavement. The story does not stop here. I have to comfort my siblings to get calm. I might admit the reason why my father left home and due to what cause my mother has died of. Nevertheless, I do not have the gut to tell my younger siblings the truth. She (their mother) was dead in silence, never disclosed. However, except the little girl both question as to what has happened. Lured by lack of proper information, one way or another they get ashamed. I suspect that they might hear rumors around and likewise they might have been stigmatized".*

### 5.4.5 Views on the Future

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. One of the FGD participants states that she wants to be a doctor because her mother used to tell her that she is a good girl to become a doctor and help sick people. Others express their future desire as follows:

> *"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."*

> *"I want to be a teacher so that I educate poor children like me."*

*"I want to be a nurse so that I help sick people with no money---*
*."*

Views of the siblings about their future 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, there has been a strong commitment of many of the female child-headed 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 caretakers – child household heads. For example, though sibling rivalry was common when their parents were alive their relationships are more often characterized 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 behavior 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 behavior.

Briefly, in this section, the study devoted to analyze the stories/reflections of the children in FGD. The following section looks at the social support mechanisms that are available to assist the female child-headed households and their family members 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.

### 5.5 The Role of Child Focused NGOs & CBOs: Addressing the Needs of FCHHs

The study attempted to examine the approach by NGOs in the study area with the aim to understand the social support mechanisms that were available to assist female child-headed households to cope with the challenges they have faced. In this regard, the researcher conducted semi-structured interviews with three key informants drawn from children-focused NGOs that were providing care and support services to FCHH through home and community based approach. 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 FCHH. This section mainly focuses on exploring the needs and relevance of the care and support services rendered by the children-focused NGOs.

The selected children-focused NGOs generally provided support to FCHH in the form of educational support, psychosocial support, health support, food and income generating activities (IGA). This indicates that the children-focused NGOs in the area have given high attention to meet the educational, psychosocial and health needs of FCHH. The remaining needs of FCHH, such as food and IGA have received little attention by these organizations.

The educational support interventions by the children-focused NGOs in the study was in the form of schooling fees, school uniforms, tutorial support, non-formal education, and

educational materials to children. However, most forms of educational support were on interventions that did not require continuous follow up of FCHH on a daily basis. The provision of psychosocial support have been given in the form of counseling, home visits, recreational support and spiritual guidance, peer education, and succession planning.

As reported by key informants and confirmed by documents review as well, health related support was one of the major interventions carried out by the children-focused NGOs in the study area. The food support by the children-focused NGOs in the study centers was on providing supplementary feeding and food rations to address the immediate food needs of FCHH, a safety net type of programme. Unlike other forms of FCHH support, a child does not receive more than one form of food support.

Designing income generating activities were often made to meet the immediate need of FCHH. Support has been provided in the form of small grants to individuals in order to carry out petty trading activities after the completion of the vocational and skill training. 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, IGA, and address a considerable number of FCHH in their respective target areas of Adama. However, by observing at the number of FCHH benefitted by the type of support/programmes, one could find significant differences. Of all the support provided, the children-focused NGOs were mostly concerned themselves

with the education, psychosocial and health needs of FCHH. The remaining prgorammes such as food, nutrition and IGA, have received relatively low attention.

### 5.3.1 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 organizational policy and strategic design mechanisms that these organizations have made to address the needs of female child-headed households. It specifically focuses on exploring the attempts the children-focused NGOs have made concerning the program planning, management and implementation activities in relation to the perceived needs of FCHH. The responses of the key informants confirmed that the care and support services they have been providing are intended to address the need of orphaned and vulnerable children in general, and the services are relevant in that aspect. They, however, stressed that the designed program interventions did not consider the gender dimensions of the impacts of HIV/AIDS

### 5.3.2. Beneficiary Selection Criteria:

Key informants were asked to provide operational definition for FCHH and child household heads by their organizations.

All key informants have expressed their view of having little or no information as to the child household heads. One of the informants even revealed that he was unfamiliar with the term of child household head. The key informants pointed out that their organizations did not intend to differentiate between female child headed households and other form of child headed households in order to avoid any form of gender-based problems. This

reflects the reality that the lack of information available on the subject covered the specific nature of the challenges facing female child- headed households, as well as the special support they need, and their specific challenges has not been sufficiently appreciated by service providers such as the children-focused NGOs in the study.

### 5.3.3 Participation of the Local Community

Question was posed to key informants were to reflect on the degree to which their current organizations have been committed to consider the local community participation in its program planning, management and implementation endeavors. The reflections indicated that the children-focused NGOs have hardly offered opportunities for the participation of the local community during program 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. During the key informants' interview, most of the children-focused NGOs mainly strive to satisfy the need and interest of their funding agency. As a result, the children-focused NGOs are 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 *Iddirs* has been by far better in *programme management and implementation* endeavors than the children-focused NGOs in the study. The Iddirs, through working with the children-

focused NGOs in the study, have shifted their focus from attending the dead to supporting the sick and the dying. Within the Iddir, 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 Iddirs 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.

Key informants were also asked to reflect on 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:

- The community helps to identify the right beneficiaries and to access them with their felt needs;
- It ensures avoidance of duplication of assistance and distributes support to those who fail to be reached by any other programmes;
- It helps the community and the target groups to realize 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 Limitations of the Programme

According to key informants in the children-focused NGOs, the major gaps in the course of programme planning, management and implementation are underlined below:

**Absence of clear policy direction:** The key informants argued that there have been no organized and concrete actions to address FCHH in Ethiopia. Because of this, most of FCHH programmes lacked a holistic approach beyond meeting survival needs, which in turn fosters the dependency syndrome 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 different offices in Adama, had no adequate involvement in FCHH programmes implemented by civil society organizations. This has created problems of acquiring adequate information on '*who is doing what*' to ameliorate FCHH problems and to address the strategic and practical needs of female child-headed households.

**Funding constraints:** Funding was a great concern and a prevailing problem for the children-focused NGOs. The key informants have cited fund shortages as their top constraint in meeting the basic needs of FCHH 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. In addition, programmes were usually focused on meeting donor's requirements rather than the targeted recipients. Funding limitations did not only limit expansion of FCHH 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** management of responses to FCHH crisis cannot be successful 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 endeavors 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 FCHH problems as a major impediment. Lack of innovative approaches to address the FCHH problem through a common strategic goal and framework was another drawback manifested due to limited networking and collaboration among actors.

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 FCHH 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 behavioral guidance for the children as they move towards adulthood. Donors exclusively determined projects with well-defined entry and exit strategies as their entry into and withdrawal from certain interventions. Often, programmes were not designed on the basis of situational analysis and strategic needs of FCHH. As indicated in the earlier section of this paper, most programmes

focused on the immediate needs and symptomatic problems of the FCHH crisis. Equally important was that these organizations had no official guidelines that direct the minimum requirements in the content and strategies of FCHH support programmes. Agreed upon guidelines would help to ameliorate problems in providing efficient and effective support to FCHH.

# CHAPTER SIX: SUMMARY, CONCLUSION AND RECOMMENDATIONS

## 6.2 Summary

There was a lot of literature available about the consequences of HIV/AIDS on child -headed household. However, little is known on the distinct impacts of HIV/AIDS on female child -headed households. Thus, the aim of the present study was to explore, using a qualitative approach, the challenges, psychological experiences and perceptions of female children carrying responsibility for female child -headed household as a result of parental death due to HIV/AIDS. Ten semi-structured interviews were conducted with female children carrying responsibility for household in Adama town, Eastern Oromoiya zone of Oromoiya National Regional State. The selection of respondents was done based on purposive sampling.

Conceptual Framework that encompasses challenges of sexual exploitation, peer pressure, dropping-out of school, concern over-livelihood, bereavement, pubertal change, psychological trauma, dependent on support of community and NGOs are required to track the impacts of HIV/AIDS on female-headed households. This is the main springboard for the conception of this study.

Data was gathered from focused group discussions and key informant interview with a group of leaders and experts from governmental and nongovernmental organizations that helped to generate the necessary qualitative information.. Secondary data were collected through reviewing relevant documents. Thus, the findings of the study are summarized below based on the sub-themes identified through review of literature and conceptual framework.

- The study showed that female child-headed households face tremendous emotional and psychological challenges, and live with the constant memory of their departed parents, who often died slowly and painfully. The majority of them experience loneliness and stress associated with shouldering an adult role at a young age.

- The study also revealed that the question of identity has confounded the female child-headed households compounded by loss of parental guidance and prevailing social stigma. They were also experiencing difficulties on properly playing parental roles while at the same time embarking on the developmental task of transition to adulthood. On top of all, as majority of the participants of case study(FCHHs) reported, they face difficulty over adjusting themselves with such pubertal changes as menarche, eminent during the period of adolescence, and worried about the need to belong to a heterosexual peer while their mobility is confined largely within the household.

- The study showed that violence against female child-headed households, which could be expressed in the form of physical, sexual or psychological harm or threats, also deprives female their rights. The study also disclosed that most of the female child-headed households dropped out of school, which of course compromises the development of skills and abilities and future prospects. This implies that female child-headed households have been deprived of the rights of basic education due to the impact of HIV/AIDS. In addition, some of the female children interviewed reported some form of abuse since becoming a female child-headed household. The forms of abuse included being beaten, being shouted at or called derogatory names by adults, being sexually abused and being made to work for little or no money

- The study also identified that the major challenges faced by female child- headed households are responsibility towards younger siblings and the obligation to take the place of the deceased parents, concern for surviving in the face of economic and social hardship, grappling with multiple and competing responsibilities, and helplessness, uncertainty about personal safety and family disintegration and discipline.

- The study revealed that female child-headed households used various types of strategies for coping with the impact of HIV/AIDS. The major ones include searching for assistance from the charity organizations, selling household assets and withdrawing savings, washing clothes, braiding hair and selling single cigarettes. The study also showed that some of the siblings of female child headed

households children have worked for payment in kind – doing household work, fetching water or making mud bricks. Most female child heads of households also mentioned irregular gifts of money or food from relatives, and help with food from neighbors if they asked.

- The study revealed that while the involvement of community and child-focused NGOs and CBOs working in child-headed households support activities generally seem encouraging, the assistance was minimal and the selection criteria of beneficiaries was not gender sensitive.

- The study found that the majority of the female child headed households do not have as such strong link any with social networks such as Iddir, Eqqub, and so on. It was indicated that they could not afford to have these kinds even Iddir, which requires less monthly payment. While some were members of the Iddir by labor contribution, a significant number of households were member of the Iddir before they were affected but discontinued after infection because of shortage of income

## 6.3 Conclusion

The epidemic has continued influencing gravely on child-headed households in general and female child-headed households in particular; and governments are on the right track in terms of appreciating the challenge and responding to it. With the strong support of the global community, they have achieved considerable progress. Nevertheless, given the scale of the challenge, a lot remains to be done and the road ahead is still daunting. According to the findings of this study, various impacts of HIV/AIDS on female child-

headed households are identified. Based on these findings, the following conclusions are drawn.

**6.3.1 Conclusion as per Objective One**: It can be inferred from the findings of the study that female child-headed households face tremendous emotional and psychological challenges, and live with the constant memory of their departed parents, who often died slowly and painfully. They have been confounded by the question of identity formation compounded by loss of parental guidance and prevailing social stigma. They also had trouble on how to properly assume parental roles while at the same time embarking on the developmental task of transition to adulthood. On top of all, FCHHs have faced difficulty over adjusting themselves with such pubertal changes as menarche that is eminent during the period of adolescence and worried about the need to belong to a heterosexual peer while their mobility is confined largely within household. Moreover, FCHHs feel anxious with resolving approach-avoidance conflict whether to establish a relationship with someone of the opposite sex while being unpleased when recalling the cause of death of either or both of her parents. With regard to child right situation, it could be concluded that The study showed that female child headed households have been deprived of their rights of protection and psychosocial support due to the violence against them, which could be expressed in the form of physical, sexual or psychological harm or threats. The study also disclosed that most of the female child-headed households dropped out of school, which of course compromises the development of skills and abilities and future prospects. This implies that female child-headed households have been deprived of the rights of basic education due to the impact of HIV/AIDS. In

addition, some of the female children interviewed reported some form of abuse since becoming a female child-headed household. The forms of abuse included being beaten, being shouted at or called derogatory names by adults, being sexually abused and being made to work for little or no money

**6.3.2 Conclusion as per Objective 2***:* Result of this study lead the researcher to infer that female child-headed households in the study area are particularly vulnerable and influenced by the impact of HIV/AIDS in a number of key ways. These are:

> **Challenges of household responsibility**: Female child headed households carry a burden of family responsibilities and roles. These responsibilities rob children of time otherwise spent playing, socializing and studying. These children experience a range of emotional responses including depression, anger, anxiety and fear, all of which raise their psychosocial vulnerability.

> **Economic Challenge**: All the child household heads and their siblings lived in abject poverty. Many of these female headed-households are unable to generate sufficient economic resources to ensure their well-being. They are vulnerable to sexual exploitation, which frequently is related to their economic vulnerability. 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 neighbors. 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.

**Challenges of Access to social services:** The study came out with the fact that education is one of the facets of the life of a child that is impacted by HIV/AIDS and by female-headed households in particular. Children of female child-headed household often drop out due to economic stress and social stigma, which acts as an additional obstacle to the continued education of the children. Female child Household heads are particularly vulnerable to dropping out of school in order to care for their younger siblings who continue with their education. In addition, they are deprived of access to improved health services due to financial problem.

**Emotional and psychological challenges:** Female 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.

**6.3.3 Conclusion as per Objective 3:** A number of NGOs, CBOs and community were involved in providing different support to female child-headed households in the study area. The support they provide was 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. 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 specific needs of female child-headed households' crisis in their respective areas. Rather, they depend on the strategies and approaches attached with donor funding. They also did not have succession plans and

proper behavioral guidance for the female child-headed households and their siblings as they move towards adulthood. Similarly, they did not analysis their program based on gender differences.

Moreover, except receiving different supports intermittently, the attachment of the female child-headed households with the social and economic net work was very loose. The study found that the majority of the female child headed households do not have any kind of social networks such as Iddir, Eqqub, and so on as they could not afford to get involved in the social networks. While some were members of Iddir through labor contribution, though a significant number of households were members of Iddir when their parents were alive.

### 6.3.4 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 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 have developed a new identity of being a responsible caretaker.

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 behaviors 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 from the study that all the female child headed households, including their siblings in the study have faced all forms of poverty and psychosocial problems because of the impacts of HIV/AIDS, which left them parentless. In these difficult circumstances, female child household heads particularity needs both material and psychosocial support, in terms of:

- Parenting skills
- Household management
- Counseling
- Economic security

The support should be gender sensitive as revealed by this study and others conducted elsewhere, the female child headed households are more vulnerable and they have their own specific psychosocial, cultural and biological problems. 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. 4 Recommendations

The following major recommendations are based on the findings from this study and are expected to make a substantial impact on female child-headed households. The researcher

recommends that all stakeholders working with children responsible for taking care of their households due to death of their parents consider these recommendations as they attempt to design a strategy to address the needs of orphans and vulnerable children in general and female child-headed households in particular.

### 6.4.1 Addressing Gender based Emotional and psychological Impact

The study showed that female child-headed households face tremendous emotional, biological and psychological challenges, and live with the constant memory of their departed parents, who often died slowly and painfully. The majority of them experience loneliness and stress associated with shouldering an adult role at a young age. Thus, the study recommends that there is a need to provide emotional, biological and psychosocial supports to female child headed households based on gender-disaggregated data rather than applying strategies that may not address the practical needs of female-headed households. Psychosocial support should be included as one component in the minimum package of services offered to the most vulnerable child- headed households in general and female child- headed households in particular.

### 6.4.2 Gender Sensitive Intervention Program

The study further recommended that all stakeholders providing support to child-headed households need to assess the gender dimensions of HIV/AIDS impact before undertaking any intervention programs since it was discovered from the study that female child headed households have been vulnerable to biological, cultural and sexual challenges which have gender differentiated impacts on children.

### 6.4.3 Improved Food Assistance to Female Child-headed Households

The study showed that female-child-headed households are more likely to suffer from hunger than their peers in neighboring households are. The study also revealed that female child-headed households are currently receiving food assistance and still do not have enough to eat. This implies that there is a clear need to make food assistance more effective to ensure adequate daily nutrition for female child-headed households. As the impact of HIV/AIDS is Gender sensitive, it is useful to look at the differences between female child headed households and other groups of household heads. Therefore, it is recommended that food assistance be granted based on vulnerability. Criteria for targeting limited food assistance would be gender sensitive and based on the income of a female child-headed household and/or its ability to provide sufficient food for all household members.

### 6.4.4 Improved Access to Social Services

This study evidenced that female child-headed households and their siblings have limited access to social services such as education and health. Concerning education, the study disclosed that most of the participants of case study were not attending their school. Some of them have already dropped out of school while others have not attended regularly. The qualitative data gives reason to believe that education of younger children living in HIV/AIDS-affected households are also disrupted. Key Informants Interview and FGDs with participants of the study provide three major reasons for female child-headed households and their siblings not attending school regularly: (1) insufficient funds for "informal" school fees, uniforms, and school supplies, (2) a need for help to work or

care for family members at home, and (3) being discriminated against in school. Thus, recommendations to improve access to education must address these barriers. The study recommends:

- Continue to identify and monitor vulnerable children and provide them with a subsidy for supplies and uniforms needed to go to school. These provisions are currently facilitated by many NGOs in Ethiopia who are serving households affected by HIV/AIDS.

- Introduce training sessions at schools to educate teachers and staff members on issues related to HIV/AIDS, including the impact of stigma and discrimination, combined with HIV-prevention education.

- Introduce non-formal education programs and vocational training in communities to adolescents not completing secondary school.

With regard to health, Children in female child-headed households suffer from lack of proper nutrition, and find it hard to access health services. Most of them live in dilapidated mud houses or under plastic shelters. All stakeholders working with vulnerable children support programs need to design strategies that can adequately address the need of female child-headed households.

### 6.4.5 Coping Strategies:

It is evident from the findings from this study that the female child-headed households who were interviewed face a number of challenges, which include shortage of food, lack of access to education, insufficient health services, sexual abuse, burden of carrying

responsibilities, etc. On the other hand, the interviewees reported that they have found different mechanisms of adjusting and coping with their situation. However, the respondents further elaborated that regardless of their effort to cope with the challenges they face, the impact of HIV/AIDS still affected them. They have not been able to tackle the economic, psychosocial and leadership challenges they are confronting due to the death of their parents. Thus, this study recommends that mobilization of communities and resources is needed to assist female child-headed households and children living with them to optimize their quality of life and future prospects in mitigating the impacts of HIV/AIDS. Moreover, there is clearly a need for programs and skills that enhance the children's ability to manage households in areas, such as, management, conflict resolution, and effective utilization of limited household resources and so on.

### 6.4.6 Involvement of Social Networks

The study found that the majority of the female child headed households do not have any kind of social networks such as Iddir, Eqqub, and so on. Thus, there is a need to create a mechanism to establish strong social networking between female child-headed households, community based organizations such as Iddir, and other child focused organizations.

### 6.4.7 The Need for Further Research

This exploratory research did not attempt to compare FCHHs with orphans in other care arrangements. To draw final and generalized conclusions regarding the gender

dimensions of the impacts of HIV/AIDS on FCHHs, there is a need for a comparative study with boy child-headed households. This study has laid the foundation for effectively conducting such further research by expanding the conceptual framework to include this sample group.

## References


Annet, K. (2006) .The Impact of HIV, AIDS Care, and Support Interventions on Household Welfare in Uganda: A Case Study of Kyanamukaaka and Buwunga sub-counties, Masaka District. Makerere University, Uganda.

Aster T. (June, 2005). The Impact of HIV/AIDS on Poverty at Household Level: The Case of two Kebeles in Adama. M.A. Thesis, Adama University

Ayieko, M. A. (2003). From Single Parents to Female child-headed Households: The Case of Children orphaned by AIDS in Kisumu and Siaya districts. HIV and Development Program, Study Paper No. 7, UNDP

Common Wealth Secretariat & Maritime Center of Excellence for Women's Health (2002). Gender Mainstreaming in HIV/AIDS: Taking a Multisectoral Approach. Dalhousie University and IWK Health Center.

Erulkar, A. & Abebaw T. (2009). Social Exclusion and Early or Unwanted Sexual Initiation among Poor Urban Females in Ethiopia, *International Perspective on Sexual and Reproductive Health, 35(4): 186-196*.

Foster G. & Williamson, J. (2000). A Review of Current Literature of the Impact of HIV/AIDS on Children in Sub-Saharan Africa. Family AIDS Caring Trust, Mutare, Zimbabwe.

Frieze, I.H. & Yu Li, M. (2010), Gender, Aggression, and Prosocial Behavior in Joan C. Chrisler, J.C. & McCreary, D.R. (eds.): Handbook of Gender Research in

Psychology, Volume 2: Gender Research in Social and Applied Psychology, Springer New York

Grainger, C., Webb, D. & Elliott, L. (2001). Children Affected by HIV/AIDS: Rights and Responses in the Developing World. Working Paper Number 23, Save the Children UK.

Gray, D.E. (2004) Doing Research in the Real World. London: SAGE Publications

Loening-Voysey, H. & Wilson, T. (2001). Approaches to Caring for Children Orphaned by AIDS and Other Vulnerable Children: Essential Elements for Quality of Service, South Africa.

Nkomo, N. (2006). The Experience of Children Carrying Responsibilities for Female child-headed Households as a Result of Parental Death due to HIV/AIDS. MA Thesis, Faculty of Humanities, Pretoria

Nyamukapa et al. (2008). HIV-Associated Orphanhood and Children's Psychosocial Distress: Theoretical Framework Tested with Data from Zimbabwe. *American Journal of Public Health, 2008; 98:133–141*(doi:10.2105/AJPH.2007.116038).

Petersen, J. & Hyde, J.S. (2010), Gender Differences in Sexuality in Chrisler, J.C. & McCreary, D.R. (eds.): Handbook of Gender Research in Psychology, Volume 1: Gender Research in General and Experimental Psychology, Springer New York

Save the Children- UK (2007). Summary of Legal and Policy Frameworks governing orphans and vulnerable children in Ethiopia

Schatz, E., Madhavan, S. & Williams, J. (2011). Female-headed Households Contending with AIDS-related Hardship in Rural South Africa, Journal of Health & Place 17 (2011) 598–605.

Seyoum Y. & Aman A. (2007) Harmonization of Laws Relating to Children in Ethiopia, The African Child Policy Forum, Adama

Shimelis T. (2010). HIV/AIDS, Orphans and Female child-headed Households in sub-Saharan Africa, The African Child Policy Forum, Adama.

Smart, S. (2003). Policies for Orphans and Vulnerable Children: A Framework for Moving Ahead. POLICY and USAID.

Smith, J.A. & Osborn, M. (2004). Doing Social Psychology Research, Glynis M. Breakwell (editor). UK: The British Psychological Society and Blackwell Publishing Ltd.

Steinberg et al. (2002). Hitting Home: How Households Cope with the Impact of the HIV/AIDS Epidemic- A Survey of Households Affected by HIV/AIDS in South Africa. The Henry J. Kaiser Family Foundation, USA.

Tshenkeng, B. F. (2009). The Psychosocial Effects of AIDS and the Development of Identity Amongst AIDS Orphans, University of South Africa.

Togom, D.K. (2009). Challenges Facing AIDS Orphans in Nairobi Kibera Slums-Descriptive study, B.A. thesis, Turku University of Applied Sciences, Kenya.

UNAIDS (2006). Report on global AIDS epidemic, Case study of the Regional AIDS Training Network.

UNAIDS & WHO (1999). AIDS Epidemic Update: December. From the UNAIDS website.

Watson, M. F., & Protinsky, H. O. (1998). Black identity development: Effects of perceived family structure. Family Relations, 37(3), 288-292.

WFP (2006). Getting Started: HIV, AIDS and Gender in WFP Programs

WHO, (2004). National AIDS programs: A guide to monitoring and evaluating HIV/AIDS support, S 162-167.

# Annexes

## Annex 1: Themes by Sub-categories

| **1. The girl child as an orphan** | |
|---|---|
| 1.1 | Feelings of grief |
| 1.2 | Bereavement |
| 1.3 | Longing for the deceased parent |
| **2. The girl child as head of a household** | |
| 2.1 | Care giving |
| 2.2 | Looking after younger siblings |
| 2.3 | Managing household assets and money |
| 2.4 | Ensuring livelihood |
| **3. The girl child as a growing adolescent** | |
| 3.1 | Experiencing pubertal changes |
| 3.2 | Growing ahead |
| 3.3 | Lack of guidance from adult |
| 3.4 | Missing peer interaction |
| 3.5 | Career aspiration |
| **4. The girl child as a woman** | |
| 4.1 | Hampered education |

| | |
|---|---|
| 4.2 | GBV including rape |
| 4.3 | Much workload |
| **5. Challenges** | |
| 5.1 | Approach-avoidance conflict |
| 5.2 | Financial hardship |
| 5.3 | Sibling disobedience |
| 5.4 | Perceived stigma |
| 5.5 | Lack of skills |
| **6. Coping mechanisms** | |
| 6.1 | Establishing a heterosexual relationship |
| 6.2 | Seeking means of income |
| 6.3 | Going out with peers |
| 6.4 | Taking substances |
| 6.5 | Religiosity |
| **7. Leadership strategy** | |
| 7.1 | Neutrality |
| 7.2 | Seeking the advice of relatives |
| 7.3 | Sobbing, hugging |
| 7.4 | Inculcating shared goals |

# Annex 2: List of Research Tools

## 2.1. Semi-Structured Interview (Case-study)

Demographic Information

Age, level of education, and current educational status

Family Structure

Description of family composition

Birth order of siblings

Age of siblings

Type of Orphanage (single or double)

**Details of Case History**

1. Can you tell me a bit about yourself? Just briefly describe to me who you are and anything else that you think I might want to know about you, including:
    a. Family background
    b. Hobbies, interests, likes and dislikes
2. Has / have your parent(s) ever been seriously sick?
    a. For how long was / were your parent(s) get sick?
3. How long has it been since one or both of your parent(s) passed away?
4. Has / Have your parent(s) disclose the cause of illness and/or death?
    a. Yes, only to family members

b. Yes, for both family members and other people

c. Not at all

5. What do you miss the most about not having either or both of your parents?
6. Could you describe some of your thoughts and feelings towards carrying responsibility for a household?

    a. Describe any pleasant / unpleasant thoughts and feelings
    b. Growing up fast or ahead of time
    c. Doing or not doing things that other people of your age can do

7. How do you describe the perceptions of siblings towards you as head of the family and about the care given?
8. What part of the experience of carrying responsibility for a household would you describe as challenging?

    a. Handling responsibilities at home and/or work
    b. Ensuring basic livelihood (food, clothing and shelter) and access to school
    c. Looking after siblings including managing difficult siblings
    d. Maintaining order and discipline at home
    e. Dealing with household assets, loans and/or savings

9. Could you describe how you deal with the challenges you just mentioned?
10. What is your career aspiration including higher education or future profession?
11. Who is doing most of the domestic chores in the household after parental lose?
12. What is the main source of income for the family?

    a. Has livelihood changed since the illness or death of your parent(s)?

13. Who has been providing care and support for the sick parent(s)?

    a. Is there any support from the community, NGOs, CBOs?

14. Could you tell me your personal experiences in relation to peers and acquaintances?
    a. Peer pressure related to going out, leisure time, and taking substances
    b. If you have ever established a relationship?
    c. If you were confronted forced or coerced sexual advance?
15. Do you have any acquaintance or intimate friend to whom you specially share your problems, concerns and needs?
16. Have you seen secondary sexual characteristics, such as menstruation?
    a. How did you react to your first menstrual blood
    b. What problems have you faced in adjusting to such changes
17. Have you perceived any stigmatization related to the cause of illness or death of your parent(s)?

## 2.2. Focus Group Discussion Guide (representatives of government offices and other stakeholders working close to the Female Child-Headed households)

Background of Discussants

1. Age
2. Sex
3. Level of education
4. Occupation, job position or role, if any

**Discussion Points**

1. How do you describe the impact of HIV/AIDS on Female-child headed households?
2. When a breadwinner gets seriously ill or die of AIDS, what are the major problems the household face?
3. How do you think are young girls heading a household coping with the impacts of the pandemic?
4. What could be done to improve the challenges faced by the girl child heading a household where parents were lost and other adults are not present?
5. When a specific household is affected with HIV/AIDS, what influence does it have on a girl child? Which are most likely to drop out, girls or boys?
6. Are female children heading households impacted by HIV/AIDS vulnerable? How?

Do AIDS orphan engage in income generating activities? If yes, in which type of activities? Is there any other comment?

### 2.3 Focus Group Discussion Guide (with Siblings of Female Child-Headed Households)

**Possible discussion questions**

1. Being orphan, how do you explain the perception of people in your community towards orphaned and vulnerable children? 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. How do you perceive the role of your sister as a female child -headed household in your home?

4. Do you think that the care and support you receive from your sister satisfies you as the services and care you used to receive from your parents when they were alive?

5. Have you observed any challenge that your sister encounter just because she is a female child headed household?

6. What are the major problems that you are facing in your homes and your main perceived needs?

7. 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?

8. Do you want to add something before we conclude and close our session?

**2.4. Key Informants Interview Guide (with NGOs, CBOs and GOs representatives)**

1. How do you describe the circumstances of orphaned households due to HIV/AIDS?
2. Have orphan households ever applied to receive support from you or other organizations? If not, why?
3. What kind of care and support is given to Female-child headed households? By NGOs, CBOs and the community
4. What kind of care and support is available from government sectors and stakeholders for Female-child headed households impacted by the pandemic?
5. How are female headed households meeting their livelihood after the death of the breadwinner of the family?

6. What challenges and concerns have you observed among Female-child headed households impacted by HIV/AIDS?
7. What kind of psychosocial support is given to households headed by female children orphaned by the pandemic?
8. Do you think young children living in female child-headed household households lack access to basic needs, such as food, clothing, and shelter?
9. What do you think should be done to protect the rights of young girls orphaned by HIV/AIDS?
10. What do you think would be the future of these young girls who assumed parenting roles?
11. What should be the role of government sectors as well as stakeholders in mitigating the problems of Female-child headed households?

## Annex 3: Informed Consent Form

The purpose of this study and my role in this study has been explained to me by the researcher.

It is my own choice to participate in this study.

I understand that my identity will remain confidential.

I have the right to withdraw from this study at any time for any reason.

**……………………………**

**Participant**

**……………………………**

**(Researcher)**

## Annex 4: A Brief Description of Participants of Case Study

| List of Case Number | Description |
|---|---|
| **Case # 1:** | She is a-16-year old female child-headed household with three siblings (one boy and two girls. She was twelve years old when her father died. Her mother left for the middle east to make money, leaving behind Melat and her three siblings The situation of interview with Melat was relaxed. The interviewee cried at some point during interview |
| **Case # 2:** | She was a 17-year-old female child-headed household. She lives with her older and younger siblings. Her father ran away after realizing that her mother was sick of HIV/AIDS. She took the responsibility of headship following the death of her mother. She was frank during the interview. |
| **Case # 3:** | She was fourteen years old female child headed household. After recognizing that both her father and mother were HIV/AIDS positive, they (parents) indulged in fierce argument and finally her mother lost her life due to ruthless hit by her father. Following that, her father disappeared and three years later, he (her father) was reportedly died of the same case. The interviewee cried during the interview. It appears as |

| | |
|---|---|
| | if the scares of her mother's demise was still fresh |
| **Case # 4:** | This interview was conducted with a 15-year-old female child-headed household. She took care of two brothers at the time of interview. During the interview, she cited the difficult she faced in terms of sexual abuse by her teacher |
| **Case # 5:** | The interviewee was a 16-year old during the interview. Her mother tested to be HIV/AIDS, while her father was not. Learning their discordant result, her father left home deserting her, a boy of four years old the pregnant mother |
| **Case # 6:** | Case # 6 was a double orphan who lost both of her parents due to HIV/AIDS. She took the responsibility of managing four families. She was confident during the interview. |
| **Case # 7:** | The interviewee was a 17-year-old female child-headed household. She lost both of her parents due to HIV/AIDS three years ago. She took parental role at this early age. She properly responded the interview. |
| **Case # 8:** | She was a 16-year-old female child-headed household. She was double orphan. She lost both parents at once. She has four siblings |
| **Case # 9:** | Case # 9 was a 14-year-old female child-headed household. She lives with her older and younger siblings. She was shy during the interview. |

| Case # 10: | She was a 17-year-old female child-headed household. She took the responsibility of headship following the death of her parents. She was clear and expressive during the interview. |
| --- | --- |

## Annex 5: Summary of Responses of Case Study Participants

**Case # 1**

**Being Head of a Household: Assuming Parental Responsibilities**

The growth of my breast and sign of my menstrual blood were both sources of mockery from male adults. They say you are now a lady, like that

**Perception of Female Child as Head of Household**

Life is difficult as a woman. You suffer a lot due to your sex. For instance, I have a brother, my twin. Almost the consequences of AIDS accumulate to me as compared to him. Even though I am the headship, handling siblings is the most challenging task. It is only my younger girl who obeys me and willing to share with me burdens of domestic chores.

**Case # 2**

**Being Head of a Household: Assuming Parental Responsibilities**

Many times, I am scared. I suspect that people here and there seem to talk about our family. The feeling of being orphan compels me stay distant out of my peers. Even if they request to join them, I hesitate to go with them creating some excuses. Yet, I feel lonely though none of them has actually rejected me.

**Challenges of Care Giving as Head of Household**

The time was hard to explain... it was hard! I lost my parents when I was fourteen years old. I began to take care of my sick mother alone when my father left home after realizing that my mother was sick of HIV/AIDS. Before she got seriously sick, she used to do everything alone, including her work as waiter. Since then, I had to look after her (my mother), two siblings as well as my grandmother. In the mean time, my mother was very ill and gave-up working as waitress- the only means of earning income for the whole family. I had to create income for the family and to be with my mother all the time because she always wanted me next to her all the time. Her situation together with the responsibility of taking care of my siblings and my grandmother forced me to withdraw my preparatory school. When my mother died, I had to arrange funeral ceremony with limited supported from the distant relative. Following the death of my mother, we were not able to stay together and my older brother was sent to a different distant place. I have ended up living with my caring for my younger brother and the aging grandma. After I lost my mother, I encountered very hard life including sexual abuse from a man who seemed to become supportive to me.

**<u>Case # 3</u>**

**Being Head of a Household: Assuming Parental Responsibilities**

I strive to execute all my responsibilities because after all I accept my headship role as a social ascription bestowed upon me. In fact, doing so is a question of morality. Yet, as a youngster, I feel pity for not able to go along with friends of my age. I question to myself: Am I becoming older than my age mates are because I have replaced the roles of my deceased parents? At the end of the day, however, I have no answer except experiencing an unpleasant emotion

**Perception of Female Child as Head of Household**

When I started giving care for my father, I was frustrated especially after I knew he had the virus. Once I was accustomed to that, my fear changes to grief realizing his eminent death. Soon misery said to have gone, and then another chapter begins when I became entirely the head of our household. I felt neither bad nor good to get into this. I think it is human to care for others: a question of morality and partly from my religious teachings

**Case #4**

**Being Head of a Household: Assuming Parental Responsibilities**

I have accepted this as my fate. Maybe, I am the sort of person that must struggle through life in-order to succeed. I think that this is what God has given me and that I must struggle. By now, I have come to accept it. I trust in God that He always support the weak people.

**Case #5**

**Being Head of a Household: Assuming Parental Responsibilities**

I feel that my childhood has been taken away from me. I am now not only a child but also I have to be both a child and a mentor at the same time. I now have to adjust from the things that I used to do before like going out to have fun. If I go out, who will look after my siblings? I have to look after them. I have to ensure that they are well and that they have food to eat. Do you think that children with parents and at my age level do the same activity that I do currently? I do not think so. Children at my age want to do their own business like going to school, playing with friends, sharing information about transition biological needs and so on.

**Leadership strategy**

I would not pronounce whatever hectic situations I am in as head of the surviving household with younger and demanding siblings. Parental loss is not an easy experience. It is family breakdown. For example, it has been three months since one of my younger brothers left home. He says he is working as "woyalla". Now he has dropped out of school. Apart from this, he appears home very rarely. His situation remains my continued embarrassment. I am afraid of the fact that he turns out to be a street boy like this. It is miserable. As I think about his separation from us, I get betrayed because it seems I am not able to control them or I don’t know perhaps I am not meeting their basic needs.

**Challenges**

I feel that I have been at the crossroad of handling parental roles while at the same time embarking on the developmental task of transition to adulthood. On top of all, I face difficulty over adjusting myself with such pubertal changes as menarche that is eminent during the period of adolescence. I usually worry about the need to belong to a heterosexual peer while I am always busy doing domestic activities

**Case # 6**

"At the start, I expected it was only looking after children but later on I know it is all about economy and handling the conduct of siblings as well replacing parents.

**Coping strategies**

What I should do to make food available: I tend to find someone to help me meet the needs of my surviving family members including me. Otherwise left with no alternative, I think of engaging in a risky sexual relationship. I feel disguised to speak about that. It is a reality facing me: my body is a giveaway for money at times. Indeed, without my internal will, against my faith unless and otherwise who cares. I am worrying if this is going to be my final fate

**Case # 7**

**Being Head of a Household: Assuming Parental Responsibilities**

Being responsible at home is tough. You know there are things that you can do... I am only human. I am still a child after all. I steel want to be like other teenagers. Before I found myself performing this role, I was not thinking about getting food, doing washing or things like that. You do not even think about enjoying, looking for future partner as children of your age because you constantly have to think about the situation at home. As a female child, I have my own biological problems like adjusting changes that happen during transition to adolescence. I have no one to share wth such issues.

**Case # 8**

**Leadership Strategy of Female Child as Head of Household**

It is not an easy task for a young woman like me to lead a family with multifaceted problems. However, I have convinced myself that I could manage and support my siblings whose parents left behind. I usually take most of the activities for myself. When needed, I divide some the works for my siblings. 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. 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

**Challenges**

The worst side of being a female child- headed household for a young girl like me is handling different concerns at the same time. What I am saying is that you cannot be a

mother, a father, a student, a sister, a girl love to establish a partner and so on at the same time. As a diploma student, I have to go school and most times when I come back from school, I have my own books and home works to do. Yet, when my siblings need something, I have to handle that as well. I cannot say this or that person will manage that everything falls on my shoulder

**Coping strategies**

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. Moreover, 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 I and my parents will meet in heaven

**Case # 9**

**Coping strategies**

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 every day. She tells me that I should pray before I go to sleep so that I do not think about my parents so much. I find praying helps me a lot.

**Case # 10**

I have been involved in it. Therefore, by now, I do not see anything wrong with it. In the beginning when my mother died--- my mother had been sick for longer time before she died. So right from the beginning I had to look after her. After my mother died, though most of the load fell on me, my siblings share some activities with me. Therefore, I do not know-I cannot say I see anything wrong with it. Well it is wrong that I have to look after children, as I am a child too. However, after all, they are my siblings; and there is nothing that I can do about it

Care giving is stressful, not merely for helping, them [the sick parents] eat, take medicine and use toilet but beyond these care giving involves providing emotional support. On top of this sometimes, you get in contact with their body fluids. I seek the help of St Mary to save me because I do not have the required skills to provide care. I fear that I might catch HIV.