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ON

ASSESSMENT OF THE ROLES, EXPERIENCES AND CHALLENGES OF CHILD HEADED HOUSEHOLDS AFFECTED BY HIV/AIDS: *THE CASE OF FIFTEEN SELECTED CHILD HEADED FAMILIES* IN SILTI DISTRICT, SILTIE ZONE, SNNPR, ETHIOPIA

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ABSTRACT

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

This exploratory study employed qualitative research methods using purposive sampling. The aim was to ascertain how child household heads affected by AIDS adapted to changed life circumstances. The study entailed fieldwork for Silti Woreda (District) of Siltie Zone, SNNPRs, where evidence was gathered from 15 selected households headed by children (aged 12 to 18), their siblings and key informants.

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

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Declaration

I declare that ‘ The Assessment of the Roles, Experiences and Challenges of child headed households affected by hiv/aids: the case of fifteen selected child headed families in silti district, siltie zone, SNNPR, Ethiopia, is my work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

SIGNATURE _____ DATE _____
(Mr. NIGUS TADESSE)

CERTIFICATION

This is to certify that **Mr. Nigus Tadesse Abebe** student of **MSW (Master of Social Work)** from **Indira Gandhi National Open University, New Delhi** was working under my supervision and guidance for his project work for the course of **MSWP-001**. His project work entitled ***ASSESSMENT OF THE ROLES, EXPERIENCES AND CHALLENGES OF CHILD HEADED HOUSEHOLDS AFFECTED BY HIV/AIDS: THE CASE OF FIFTEEN SELECTED CHILD HEADED FAMILIES IN SILTI DISTRICT, SILTIE ZONE; SNNPR, ETHIOPIA***, which he has been submitted is his genuine and original work.

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LIST OF ACRONYMS

ACPF	AFRICAN CHILD POLICY FORUM
AIDS	ACQUIRED IMMUNODEFICIENCY SYNDROME
ANRS	AMHARA NATIONAL REGIONAL STATE
ART	ANTI-RETROVIRAL TREATMENT
BOLSA	BUREAU OF SOCIAL AND LABOUR AFFAIRS
CBO	COMMUNITY BASED ORGANIZATION
CRC	CONVENTION ON THE RIGHTS OF THE CHILD
CRDC	CHILD RESOURCE DEVELOPMENT CENTRE
CSA	CENTRAL STATISTICS AUTHORITY
ETB	ETHIOPIAN BIRR (CURRENCY USED IN ETHIOPIA)
FDRE	FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA
HACI	HOPE FOR AFRICAN CHILDREN INITIATIVE
HAPCO	HIV/AIDS PREVENTION AND CONTROL OFFICE
HIV	HUMAN IMMUNODEFICIENCY VIRUS
HSRC	HUMAN SCIENCES AND RESEARCH COUNCIL
IGA	INCOME GENERATING ACTIVITIES
ILO	INTERNATIONAL LABOUR ORGANIZATION
MEDAC	MINISTRY OF ECONOMIC DEVELOPMENT COOPERATION
MOH	MINISTRY OF HEALTH
MOJ	MINISTRY OF JUSTICE
MOLSA	MINISTRY OF LABOUR AND SOCIAL AFFAIRS
MYSC	MINISTRY OF YOUTH, SPORT AND CULTURE
NGO	NON GOVERNMENTAL ORGANIZATION
OVC	ORPHAN AND VULNERABLE CHILDREN
UN	UNITED NATIONS
UNCHS	UNITED NATIONS CENTRE FOR HUMAN SETTLEMENT
UNCRC	UNITED NATIONS CONVENTION ON THE RIGHTS OF A CHILD
VCT	VOLUNTARY COUNSELLING AND TESTING

CHAPTER ONE

1. INTRODUCTION

1.1. BACKGROUND OF THE STUDY

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

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

According to a recent estimate, for example, though there is a significant reduction in new HIV infections, Sub-Saharan Africa continues to be the region most affected by the AIDS epidemic (UNAIDS World AIDS Day Report, 2012). The number of people dying from AIDS-related causes in sub-Saharan Africa declined by 32% from 2005 to 2011, although the region still accounted for 70% of all the people dying from AIDS in 2011 (UNAIDS 2012: 2) and more than 90% of the children who acquired HIV infection in 2011 live in sub-Saharan Africa (Global Report 2012: 42) . Ethiopia is one of the few sub-Saharan countries showing a decline

of more than 25% in new HIV infections (HAPCO 2012: 12). According to mathematical modeling estimates there are nearly 789,900 people currently living with HIV/AIDS (607,700 adults and 182,200 children aged 0-14 years); and 952,700 AIDS orphans (EPP/Spectrum estimates 2011; HAPCO 2012: 13).

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

The world thus far faces an estimated 13.4 million orphaned children due to AIDS-related parental deaths. Out of this number sub-Saharan Africa is home for an estimated 12 million children who lost their parents due to AIDS-related deaths (UNICEF 2007:24). By the year 2012, an estimated 16 million children under the age of 18 in Africa could have lost one or both parents due to AIDS (UNICEF 2005). The growing pressure the AIDS epidemic exerts on both household and community is shown by the increase in elderly caregivers and child headed households in severely affected African and Asian countries. There are generations of children in Africa whose development is being challenged due to the results of the AIDS epidemic. The decline in standards of living for young children is clear evidence of this. This phenomenon partly exerts pressure on the already fragile services provided by the state and community.

Much has been said about the plight of orphan children in the world and in Africa as well, but the concern to recognize child household heads as a special group is less common despite significant differences that exist between child household heads and orphan children who are cared for by grandparents or other extended family members. This lack of concern impedes the needed urgent attention to child household heads. The main difference between orphans in general and child heads of households in particular is that the latter do not and cannot rely on adult care, guidance and protection, and do not receive strong family support. The child is left on her/his own and is responsible for sustaining the family with both material and emotional support. Those child headed households that do exist can be expected to have greater needs and vulnerabilities than households headed by an adult and may also be less able to earn sufficient

money, protect themselves, deal with the legal system or make good decisions in their day to day lives (UNICEF 2005: 17). This problem necessitates an in-depth investigation mainly to understand and ascertain the *underlying causes* and *challenges* of child household heads affected by AIDS in household care giving efforts. These main concerns of this study will be discussed in further detail below.

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

1.2. STATEMENT OF THE PROBLEM

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

providers, social scientists and the community because it poses enormous unknown challenges to existing modalities of social protection and legislative action (The African Child Policy Forum 2008).

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

Thus, this research will address the marginalized groups of fifteen selected child household heads affected by AIDS, and aimed to fill the gap in the hope that it will contribute to interventions and planning support mechanisms.

1.2.1. RESEARCH QUESTIONS:

This research will focus on the following basic questions:

- How child household heads between the ages of 12 to18 in Silti District, who lost their parents to AIDS, cope with the challenges of caring for themselves, their younger siblings and preparing for their future?
- What are the social, economic and developmental challenges that child household heads face when taking on the role of parents at an early age (both before and after the death of parents)?

- Do child household heads assume full adult roles as household heads, or do they try to fulfill their needs, desires, and aspirations associated with youth?
- What support mechanisms and other networks shall exist in order to assist child household heads and their siblings?

1.3. Objectives of the study

1.3.1. General Objective

The major objective is to assess the roles, experiences and challenges of child household heads and to present the findings of this investigation to relevant people in order to inform policy, advocacy and programmatic interventions.

1.3.2. Specific Objective

Specifically, the study will focus on exploring:

- The economic, social and developmental challenges faced by child headed households affected by AIDS.
- The resilience/ coping mechanisms that are adopted by child household heads in order to address the challenges associated with performing parental roles.
- The relation of authority that exists between household heads and their younger siblings.
- The support mechanisms that exist for child headed households affected by AIDS in Silti District.

1.4. DEFINITIONS OF TERMS

1.4.1. CHILD

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

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

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

1.4.2. ORPHAN

According to Hepburn (2002:88) "orphan" is a socially constructed concept the meaning and content of which varies among cultures and countries. For example, in some cultures it refers to children who have lost one parent, while in other cultures the term is reserved for children who have lost both parents. Lindblade et al (2003) describe an orphan as a child who has lost either or both parents and further refine the categories as maternal, paternal, and double (both parents deceased). In most instances, the difference is related to the specific emphasis. For example, in Namibia an orphan is any child under 18 years that has lost a mother, a father, or both as a result of death (Smart, 2003). The definition also includes a child in need of care.

The definition of an orphan in Botswana includes children that have lost a single parent or both parents where the biological or adoptive parents are married (Smart, 2003). Other definitions are influenced by cultural modes of understanding. For example, among the Shona-speaking group in Zimbabwe, isolated child-headed households and children residing in city streets are

regarded as orphans because their needs may often not be met (Roalkvam, 2005). According to this definition, a child or children cannot be labeled as orphans for as long as their needs are met, regardless of whether their parents are alive, ill, dying or deceased.

In South Africa, an orphan is defined as a child that has no surviving parent caring for him or her after one of the parents has died (Draft Children's Bill, 2002). In most countries, children that have either lost one or both parents are generally recognized as orphans.

In Ethiopia, the definition relates to any child under 18 who has lost both parents, irrespective of how the parents died.. In this study orphan refers to a double orphan whose parents have died from any cause but AIDS was the cause of death for either one or both parents of the orphan child.

1.4.3. HIV and AIDS:

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

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

The social construction of the disease is such that it is associated with stigma, ostracism, repression and discrimination as people with HIV or AIDS and their families have been rejected by their communities in different social settings. The rejection holds as true in the rich countries of the north as it does in the poorer and developing countries of the south due to differing social speculations and misconceived notions people have about HIV/AIDS. Early speculations of HIV/AIDS, which suggest that it is a 'woman's disease', a 'junkie's disease', a 'black disease', an 'American disease' or a 'gay plague' are clear evidence of this. Some of these speculations are still rampant in many parts of the world. In fact, these speculations do

not arise out of the blue, nor is something dreamed up in the minds of individuals. Instead, like responses to diseases such as leprosy, cholera and polio in the past, it reflects deep-rooted social fears and anxieties (Loeing-Voysey and Wilson 2001).

Also, such speculations and constructs build upon and reinforce earlier negative notions. People with HIV/AIDS are often believed to have deserved what has happened by doing something wrong. Often these ‘wrongdoings’ are linked to sex and socially frowned-upon activities, such as intravenous drug use. Men who become infected may be seen as homosexual, bisexual or as having had sex with prostitutes. Women with HIV/AIDS are viewed as having been ‘promiscuous’ or as having been sex workers (Weeks 1981).

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

1.4.4. Grief

Grief is the emotional reaction resulting from longing for someone or something that is no longer there (Sherr, 1995). The term, however, is often used in connection with the death of a person. In the literature, grief is usually described in terms of stages or phases. For example, Bowlby (1980) defines grief in terms of the following phases: numbness; yearning and anger; disorganization and despair; and reorganization

It is widely recognized that children do not experience these phases in the same way as adults do (Sherr, 1995). In the case of adolescents, emotions predominant during this developmental stage are intensified by the loss of a parent (Ruland et al., 2005).

In a general sense, the term grief refers to “the dysphonic feeling or affective response to the death of a loved one” (Clark, Pynoos & Goebel, 1994, p.101). This definition will also be used for the purposes of this research.

1.4.5. Mourning

According to Kubler-Ross (1969), mourning comprises the following stages: denial and isolation; anger; bargaining; depression; and acceptance. These stages are, however, not inevitable or rigid in their occurrence. In broad terms, mourning “describes the internal process of adaptation to death that culminates in an appropriate or maladaptive adjustment. Mourning also includes social rituals and other expressions of grief (Clark et al., 1994, p.101). Sherr (1995) cautions that even though the phases and stages expounded by the various theorists in the literature on both grief and mourning are helpful and useful in describing the emotions and experiences common for people going through these processes, they can never capture the nuances of each individual experience.

1.4.6. Bereavement

Bereavement is thought to be “... an umbrella term encompassing both the feelings of grief and the process of mourning – it represents the social process of coping with an emotional response due to death” (Clark et al., 1994, p.101). Due to the meaning and stigma attached, a certain amount of doubt exists as to the applicability of the definitions, stages and processes discussed in the literature on grief, mourning and bereavement in the HIV/AIDS scenario (Sherr, 1995). For the purposes of the present study, these definitions are, however, sufficient.

1.4.7. Child Headed Households:

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

Sometimes, children who still have caregiver, but whose caregivers are terminally ill with HIV/AIDS, though not strictly speaking orphans would be in the category of child headed households. When parent(s) become too sick to do what is necessary, these children assume the responsibility of heading the household.

As Sloth-Nielsen (2004:15) puts it: “child headed households in which there is no effective adult caregivers generally do the same as families: work to support siblings, get food, clothing and shelter, and deal with the emotional well-being of their members.”

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

1.4.8. Poverty and being an orphan

Poverty contributes to the AIDS epidemic and the AIDS epidemic contributes to poverty: causation is bi-directional and occurs through many different pathways. For example, loss of labor from a farming system may result in failure to maintain infrastructure such as terracing, leading to soil erosion, and decreasing agricultural productivity (Barnett and Alen 2006). In similar vein, Stillwagon (2000: 985-1011) argued ‘that HIV prevalence is highly correlated with falling calorie consumption, falling protein consumption, and unequal distribution of income’. The epidemic can impoverish households and reduce communities’ ability to sustain them which in turn will result in less formal education that also leads to impoverishment. That the HIV/AIDS epidemic impoverishes people, their households and communities is by now widely accepted.

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

The concept poverty is multidimensional, which is defined by several approaches. One of these approaches is **the biological approach**, which conceptualizes poverty as the inability to meet the requirements for survival. One is defined as poor if he/she fails to meet certain basic needs, such as food, clothing and housing (Sen 1981). According to this approach, people lack the basic necessities that are needed for survival (food, water, shelter and clothing).

The second approach, known as **the normative approach**, conceptualizes poverty in terms of a value judgment about the minimum adequate level of welfare below which one is said to be poor. The process of defining the minimum adequate level of welfare is subjective. It depends on norms and values as they have been used over time and in a specific community and has resulted in variations on the definition of the concept of poverty (Ibid.).

The social-poverty-approach is the third approach that views poverty as a reflection of social inequality such as lack of wealth and the absence of opportunities to exercise fundamental human rights, such as equality before the law and the right to life (Chalfant and Labeff 1988: 142-149).

Conceptualization of poverty also differs from country to country. Categories such as ‘chronic poverty’ and ‘mass poverty’, for instance, are used to characterize poverty in developing countries. Chronic poverty refers to the state of being poor and failure to move out of it. It includes households without basic necessities for survival, with low quality of land (especially in rural areas) and insufficient productive assets, with low or no access to education, health and sanitary facilities. The main thrust of the chronic poverty argument is that poverty is inherited and passed on from one generation to the next (Sen 1981). Poverty in Ethiopia is characterized as ‘mass poverty’, which is explained as a situation where the income of more than half of the total population is less than 1 US dollar a day (MEDAC 2000).

Variations on the measurement of poverty are also apparent, especially focusing on the alleged distinction among ‘absolute’, ‘relative’ and ‘subjective’ poverty. The definition of absolute poverty is associated with subsistence poverty. It can be defined as a situation of not having enough to get by or not having enough to meet one’s needs, while relative poverty is

characterized by a situation of relative deprivation that depends on the general style of living in a society. It means that basic needs may be met, but those at the very bottom have less access to other social expectations. The approach to a subjective poverty paradigm is eliciting local people's conceptions of poverty/ deprivation and to harness their own priorities in the complex and heterogeneous societies in which they live (Chambers 1995). This approach explicitly recognizes that poverty is an inherently subjective judgment of individuals about what constitutes a socially acceptable, minimum standard of living in a particular society.

Explaining poverty and being an orphan can be regarded as both an easy and a difficult task. It is not an easy task as variations of the concepts of poverty and orphan still exist, which may create less certainty to provide concrete evidence on the subject. It is not a difficult task as it could be best explained from the experiences and the living conditions of orphan children. For example, it is evident that the increasing effects of the AIDS epidemic jeopardize the rights and well-being of orphan children. This is supported by studies from UNICEF (2003b:26) which states, for instance, that AIDS orphans are likely to suffer damage to their cognitive and emotional development, have less access to education and are subjected to the worst forms of child labor.

Additionally, orphans run a great risk of being malnourished and growth-stunted compared to children who have parents to look after them (Confronting AIDS 1999: 223-24). A lack of schooling is often combined with a lack of proper nutrition which makes it particularly difficult for orphans to escape poverty.

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

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

It is also evident that orphan children suffer emotionally as a result of the deprivation of parental guidance, emotional trauma as a result of loss of parents, the problem of having to cope with adult responsibilities prematurely, and vulnerable to physical and sexual abuse by neighbors and relatives. This is exacerbated by the stigma and discrimination attached to HIV/AIDS. In addition UNICEF (2003a:2) lists some other experiences these children have:

- **Economic hardships.** With parents unable to work and savings spent on care, children are forced to take on the adult role of supporting the family.

- **Having to leave school.** The pressure of having to care for parents and siblings and trying to earn an income can cause children to drop out of school, even while their parents are still alive. The pressure to abandon schooling intensifies when one or both parents die.

- **Malnutrition and illness.** Orphans and other affected children are more likely to be malnourished or to fall ill. They are also less likely to receive the medical attention and healthcare they need. Poverty is the root cause of this vulnerability, but often neglect and discrimination by adults in whose care they have been left, are also contributing factors.

- **Loss of inheritance.** When parents die, orphans are often cheated out of property and money that are rightfully theirs.

- **Fear and isolation.** Dispossessed orphans are often forced out of their homes to unfamiliar and even hostile places, be they camps for the displaced or the streets.

• **Increased abuse and risk of HIV.** Impoverished and without parents to educate and protect them, orphans and other affected children face every kind of abuse and risk, including becoming infected with HIV themselves. Many are forced into exploitative and dangerous work, including exchanging sex for money, food, protection or shelter.

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

1.4.9. Theoretical Approach

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

1.4.9.1. Erikson's developmental theory

Psychosocial theory is viewed as a product of the interaction between the individual needs, abilities and social expectations and demands (Newman & Newman 1999:34). In the same vein Loughry & Eyber (2003:1) see "psychosocial" as a close relationship between psychological

and social factors. Psychological factors concern emotional and cognitive development (the capacity to learn, perceive and remember), whereas social factors are about the ability to form relationships with other people and to learn and follow culturally appropriate social codes. According to Erik Erikson's model of the eight stages of development each stage is unique and leads to acquisition of new skills. During each stage the person is confronted with a unique problem, which requires the integration of personal needs and skills with the social demands of one's culture (Newman & Newman 1999:284). The box below represents Erikson's psychosocial development stages. One will note that the periods of life are given names such as oral-sensory or puberty and adolescence, without specific ages.

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

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

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

Figure 1

8. Maturity								Ego integrity vs. Despair
7. Adulthood							Generativity vs. Stagnation	
6. Young Adulthood						Intimacy vs. Isolation		
5. Puberty and Adolescence				Identity vs. Role confusion				
4. Latency			Industry vs. Inferiority					
3. Locomotor genital		Initiative vs. Guilt						
2. Muscular-anal	Autonomy vs. Shame, doubt							
1. Oral-sensory	Basic trust vs. Mistrust							

1 2 3 4 5 6 7 8

Erikson's (1963:245) model of psychosocial stages of development

Source: Erikson, 1963. Childhood and Society.

These stages play a vital role in the development of human beings. Erikson's model will be applied to the situation of children who lose their parents and family systems due to HIV/AIDS during the younger stages of their lives. Conclusions will be drawn as to how the events surrounding HIV/AIDS may affect the development of these children, since infants use their mothers or other primary caregiver as a social reference.

The first stage in Erikson's model is that of *basic trust versus mistrust*, which is also known as the *oral-sensory* stage. The psychosocial crisis, according to Newman & Newman (1999:169) is the struggle between the positive and negative poles of a critical inner dimension. Trust versus mistrust fundamentally focuses on the infant's sense of connection to social world. Newman & Newman (1999:169) argue that trust is about the predictability, dependability, and genuineness of relationship as one person discovers those traits in another person. This trust is the faith that relationship will survive uncertainties and unpredictability should they occur. Trust is the integrating force, which helps to synthesize emotions, cognition, and action under irregular circumstances. Infants have emotional trust in people or they may mistrust them. Mistrust arises when an infant lacks confidence in the caregiver and doubts his/her own lovability.

Infants show "startled" reactions to loud noises and mono reflexes to sudden loss of support. In order to promote the building of trust in child caregivers should try to minimize the infant's exposure to stimuli which evoke reflexes. Such a caregiver should be able to comfort and reassure the infant that he/she is in tune with the infant's needs and able to respond appropriately. When infants are cared for by adolescents who are little more than children with need themselves, the babies will most likely be neglected at times and left without anyone to care for their needs. Infants then discover that reliable care is physically and psychologically unavailable.

Parents play an important role in promoting the psychological growth of their children. They also ensure the safety of children and protect them from environmental dangers. In an African context mothers carry infants of up to 18 months or older on their backs, even when they are already able to walk. This is one way of protecting them from danger though this may limit the child's exploratory behaviour. HIV/AIDS orphans who are responsible for the household and caring for siblings are inexperienced in child rearing. They cannot give infants what they need in terms of physical protection. Parents also play a major role in promoting the emotional and cognitive development of the infant. Boeree (1997:5) argues that if parents can give a newborn a degree of familiarity, consistency and continuity, then the child will develop the feeling that the world, especially the social world, is a safe place to be, that people are reliable and loving. If these aspects are not present in the life of a young child, the social world will be experienced

as threatening and approached with suspicion. At the other extreme, parents who are over protective of their children cause what Erikson calls sensory maladjustment. Children, whose balance tips over to the side of mistrust, develop the unhealthy tendency to withdraw, which is characterized by depression paranoia and possibly psychosis (Boeree 1997:6).

Stage two has to do with self-confidence or self-esteem and is about feeling confident. The crisis at this stage is *autonomy versus shame*. Parents are there to encourage toddlers when they develop language and muscle control. Children absorb vast amounts of new information about world and self. If parents are overprotective or disapproving of the toddlers' acts of independence, the children will feel ashamed of their behaviour and develop doubts about their abilities.

Stages 1 and 2 are critical for social formation. When parents die at these stages of development and the formation of social skills and interaction, and there is no adequate replacement of the primary caregiver, the child will most probably regress.

Stage three represents the crisis of *initiative versus guilt*. The task of the child in this stage is to learn initiative without acquiring too much guilt. Boeree (1997:7) refers to initiative "as a positive response to the world challenge, taking on responsibilities, learning new skills, feeling purposeful." It is the attempt to make non-reality a reality. Parents should encourage children to experiment, but should also be consistent with their discipline. Then children will learn to accept that certain things are not allowed while at the same time they do not feel shame when using their imagination and engaging in make believe role-play. However, if this process is approached harshly and too abruptly children will feel guilt about their feelings. The ideal is that children reach early school age with a strong sense of themselves as unique individuals. At this age they like to draw attention by asking questions. Pennington (1986:39) argues that during this stage sex role and other role definitions, for example social class begin to take shape. Failure to develop a sense of purpose results in a lack of independence and a persisting sense of guilt over this failure.

When others are unhappy or there is conflict they tend blame themselves. The psychosocial crisis of this stage highlights intimate and emotional development (Newman & Newman

1999:28). Children should develop a strong internal moral code, which makes constant discipline unnecessary.

At stage four the psychosocial crisis is *industry versus inferiority*. This stage is also known as latency or school age. Children form relationships with teachers and other adults. The developmental task is to learn friendship skills, self-evaluation and team play. In the previous stages parents played the most important role in the development of the children, but now teachers, peers, other family members and other members of the community also have a great influence. Peers can encourage children in the acquisition of skills, but they may also receive some negative input from others. Children in this stage become interested in real life roles and play at being doctors, nurses, fire fighters, pilots and the like. They gain self-confidence and competency. When parents die at stage 3 or 4 when the children are trying to envision themselves as adults, they tend to feel helpless and discount their success. Often they are not positive about the future. According to Boeree (1997:8) the role of parents is to encourage, teachers to care and peers to accept. It is vital that “children must learn the feeling of success, whether it is in school or on the playground, academic or social” (Boeree 1997:8). It is especially devastating for HIV/AIDS orphans in these stages when they have to face stigma, discrimination, isolation and scorn by the peer group, community, family members and some teachers. Worst of all is the loss of the parent(s) who were supposed to be their guide, give them courage, nurture and teach them how to cope with the basics of life. If children at this stage do not experience success they will have trouble developing a capacity for industry and will develop a sense of inferiority or incompetence. Other sources of inferiority are: racism, sexism, and other forms of discrimination. Children, who already see themselves as inferior or incompetent in the eyes of other, can become totally apathetic. Role models who are able to help HIV/AIDS orphans to tip the scales to industry rather than inferiority are sorely needed so that these children can develop competency.

Stage five is adolescence. It begins with puberty and ends around 18 or 20 years of age. The emphasis of this stage is on learning to cope with the demands of rapid physical growth. Gillis (1994:72-75) mentions three stages of adolescence: child adolescence (\pm 12-14 years), mid-adolescence (boys \pm 14-16yrs; girls \pm 13- 16 yrs), and adult adolescence (\pm 17-20). The task

during adolescence is *ego identity versus role confusion*. Kail & Cavanaugh (1996:215) call adolescence a “recent cultural invention”. The reason is that for much of recorded history, “children moved directly into adulthood, when they were considered to be young adults.” As adolescents approach the adult world they struggle to achieve an identity which will allow them be well prepared to face new developmental challenges such as intimacy, and sharing relationships with others (Kail & Cavanaugh 1996:260). Adolescents are in search of their ego identity, which are a conscious sense of individual uniqueness as well as psychosocial sense of well-being (Adam & Berzonsky 2003:206). This stage is marked by rapid changes. Although these changes may make them feel like adults, they are not ready to assume the tasks of adults, such as for example being parents.

Pennington’s (1986:41) states that the search for one’s “true self”, or attempts to answer the question “who am I?” preoccupy teenagers. When parents die at this stage of the children’s lives, adolescents have to take responsibility for siblings, which may be traumatic for both the adolescent and the younger children. While other youth are involved in dating relationships, HIV/AIDS orphans as heads of households have to look after siblings and assume adult roles and responsibility.

Adolescents in early and mid-adolescence rely more heavily on peers than on family. Later in adolescence they gain the confidence to rely more on their own priorities when choosing friends and initiating relationships. Then they are less open to influences and manipulation from the peer group. In situations of stress the support of peers may not be as strong or as present (Loughry and Eyber 2003:15). However, the stability and support provided by the family is significant.

Teachers should be encouraged to genuinely care for all children. Children should get to know the feeling of success, whether it is in school or on the playground, academically or socially. This does not happen for HIV/AIDS orphans who have to face stigma, discrimination, isolation and scorn by their peer group, the community, family members and also some teachers. If parents who are supposed to guide, encourage, nurture and teach the basics of life are not there, these children are left to their own devices in extremely stressful circumstances.

In preparation for the transition from childhood to adulthood, a number of so-called “tasks” or challenges in each area of development must have been completed for the young person to be prepared for a successful adult life.

According to Gillis (1994:71) these tasks are not simply chores but a series of highly personalized experiences that will help adolescents to cope with obligations, demands, and pressures of adulthood. These tasks include:

- adjusting to changing body growth;
- mastering new, complex ways of thinking;
- dealing with awakening sexuality, and the powerful drives which accompany it;
- achieving a satisfactory sexual identity;
- learning to relate to peers and to society in a mature way;
- attaining emotional independence from parents, family and other adults;
- accepting adult responsibilities, and socially acceptable values and behavior;
- choosing a vocation, and establishing economic independence;
- preparing for marriage and family life.

All these “tasks” are steps through the development of adolescents from which they will emerge with a positive or negative self-concept. Self-concept, according to Gillis (1994:79), is a “general term used to describe the way in which individuals perceive themselves.” Self-concept is used interchangeably with “self-esteem”, which refers specifically to the personal assessment of the value or worth individuals place on themselves. This value according to Gillis (1994:79) can be expressed either positively, for example: “I am a capable person” or negatively as in “I’m a loser” or “people don’t seem to like me”.

Depression is common in adolescence, because of the many pressures they face -the pressure of being a teenager and having friends, who do not understand them; and pressure from parents or other caregivers. For those who have no parents due to HIV/AIDS there are the pressures of having to take care of oneself and others, and of being ostracized by peers and isolated from family and community. In the case of HIV/AIDS orphans who become heads of households depression is triggered by the loss of parents through the debilitating disease of AIDS. Furthermore they have to take on a role far above their abilities and they have to do so in circumstances of poverty, worrying every day about finding something to eat. Depression deprives teenagers many rewarding experiences and interactions.

As adolescents grow they are faced with physiological changes in themselves and the tasks of adulthood lying ahead of them. HIV/AIDS orphans have prematurely been forced into these

tasks. Erikson (1963:235) calls adolescence a state of “moratorium” which means a psychosocial stage between childhood and adulthood, and between the moralities learned by the child and the ethics to be developed by the adult.

Stage six the strength acquired from previous stages is tested. Young adults are eager to fuse their identities with that of others. They are ready to commit themselves to affiliations and partnerships and to develop the ethical strength to abide by such commitments. The psychosocial crisis at this stage is *intimacy as opposed to isolation*. According to Boeree (1997:10) intimacy is the ability to be close to others, as lovers, friends, as a participant in society. Those who have successfully negotiated this, carry with themselves for the rest of their lives the psychosocial strength Erikson calls love. This love does not only include the love to be found in a good marriage, but also the love between friends and the love of one’s neighbor and compatriot. This stage sometimes is regarded as the late adolescence. The crucial task in late adolescence is the search for a long term commitment to a marital partner or other companion with whom one can express one’s need for intimacy and care for the needs of the other (Gerkin 1997:175).

There is a significant number of orphaned young adults who are heads of households who mostly live in poverty, have no income and are rejected by their families on account of the stigma of HIV/AIDS. The focus of this study, however, is not on young adult heads of households, but on children who experience their lives as traumatic. Therefore I will not elaborate further on this particular stage except just to point out that, if this stage is built on the strengths acquired in the previous stages, and young AIDS orphans had little opportunity to acquire strengths, the stage of young adulthood is bound to be very difficult, if not disastrous for such a person.

Stage seven is the phase middle adulthood. The psychosocial crisis at this stage is *generativity as opposed to stagnation*. The primary concern of generativity is to establish and guide the next generation. This stage includes the period in which individuals are actively involved in raising children. Generativity, according to Erikson (1963:240), is an essential on the psychosexual as well as psychosocial schedule. Erikson disputes the fact that having or even wanting children qualifies one to “achieve” generativity. Boeree (1997:11) also agrees that there are other ways to attain generativity, such as teaching, writing, invention, the arts and

science, social activism and contributing to the welfare of future generations, for example. Concerning HIV/AIDS orphans who have been abandoned by extended family members, these uncles and aunts seem to have tipped to the side of stagnation rather than generativity in their attitude towards a younger generation in need. Boeree (1997:11) points to another crisis of middle adulthood, namely the “midlife crisis”, where people want to imagine younger than they are. Those who resolve the crises of this stage successfully will have a capacity for caring that will serve them well throughout their lives.

Stage eight is about the psychosocial crisis of ego integrity versus despair. Some people do not reach ego integrity because of problems earlier in life, which have retarded their development. Characteristics of ego integrity are memory, reasoning, information processing, problem solving abilities and the adult capacity to introspect and to assess his/her personal history (Newman & Newman 1999:471). These characteristics are called “intellectual capacities” and they influence the adult’s ability to remain involved in productive work. Social scientific research has established that satisfaction in marriage contributes significantly to psychologically well-being. Integrity, as mentioned in Erikson’s theory, refers to the ability to accept the fact of one’s life and face death without fear (Newman & Newman 1999:494). This stage is the result of all the precious psychosocial crises, which, if resolved successfully, have contributed to ego strength.

1.4.9.2. **Transition into adulthood in an African context**

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

females. In spite of their lack of training for adulthood, adolescents in the society are understandably eager to be permitted to undergo this rite in order to enjoy adult status. Once they have undergone the ceremony, only a brief, intensive period of ‘*indoctrination*’ prepares them for their new roles.

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

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

Now, what seems to be important is that both Erikson’s conception and the debate over the issue of adolescence in the African context are based on the assumption of adults (usually parents) taking on caring roles towards children. It means that according to Erikson’s conception, for example, despite being cared for by their parents, the adolescents may lose their own personal identity in a struggle between dependence and independence of themselves, especially from their parents – since this developmental stage is turbulent. Contrary to this, views from the African context illustrate that the transition from childhood to adulthood is smooth rather than turbulent since children in Africa are given different tasks and roles as adults so that children do not experience role confusion.

Beyond these particular different views however, new and emerging challenges face most African countries in dealing with an ever growing number of child household heads – partly

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

Summary of the Main Themes

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

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

I have also looked at Erikson's psychosocial theory on child development, with an emphasis on children between 12-18 years of age. I have examined the positive and negative outcomes of this developmental stage (adolescence) as described by Erikson. Equally important was that I have made attempts to overview the debate over the issue of adolescence in the African context as the concept of a distinct developmental period of adolescence has often been seen as a Westernized phenomenon, with progression from child to adult in the African context being more abrupt and marked by rituals and 'rites of passage'. I argued there that both the theory and the debate over the issue of adolescence in the African context were held under the normal circumstance of parenting despite the fact that the AIDS epidemic has left sub-Saharan Africa with an ever growing number of child household heads with their own unique needs and challenges. Thus, with the belief that I am pragmatic - leaving the importance of theory as well

as the debate over the issue of adolescence in the African context a side - I suggested that we (Africans) had better focus on the response to promote the well being of this unique and special group in our society.

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

1.5. Limitations of the study

Time constraints will be an apparent limitation of the study. Because the proposed qualitative method will need more time to have a deeper understanding of the issues to acquire the desired information from the respondents. However, since I am aware of the research area and the research targets, I will manage the fieldwork within the assigned time frame.

Moreover, time will also be a constraint not only from my side but also from respondents that shall need to spend a big share of their time with me which clashes with their personal and household responsibilities and priorities. But, to address this problem, appropriate time will be arranged in consultation with the research participants.

There will also apparent limitations emanating from the very nature of the research method, that is, the small sample size that will draw with a purposive sampling method. The total number of research participants is not intended to show a universal societal reality and way of life as generalizations to the broader population. However, this problem of a small number of research participants is balanced by the depth of exploration and flexibility that the method allows, and the stories of the children in this study will give rich information in terms of roles, life experiences and choices made by the different child heads.

1.6. Universe of the Study

This research study is proposed to be conducted in SNNPR, Siltie Zone, Silti District. The district consists of 8 woredas and three city administrations. Almost 99% of the community is followers of Muslim religion, which condemn the use of condom during sexual intercourse and instead encourages people to abstain from having sexual intercourse with multiple partners. However, due to the inaccessibility of the information on HIV and AIDS and the lack of

alternatives to use condom as the last resort many people including youth groups are becoming victims of the virus. There are also traditional annual and periodic events like ‘Alkesye’, night dance and night market in which many women are exposed to sexual abuse and unsafe sex which makes them vulnerable to HIV/AIDS and other sexual transmitted infections. Due to this fact there are many child headed households who lost their parents owing to HIV/AIDS epidemic. Thus, the study is aimed at assessing the roles, experience and challenges of 15 child headed households among seventy five OVCs who lost their parents due to HIV/AIDS infection through purposive sampling technique. In addition, three experts from the woreda women and children affairs office and Aynage Child and Family development organization, who provide direct assistance to these vulnerable groups, will be interviewed.

1.7. Background of the study area

According to the housing and population census of the year 2007, the total population of the district is 177,323 where 87,583 are male and the rest 89740 are female. Information obtained from district administration shows that the total number of households are 32,650 of which 4040 are female. Accordingly, the average family size is 5.43 which is above the national average. The age pyramid of the district is heavy bottom where 43% of the total population is below 15 years old, of which 18% are below five years old. According to the woreda women and children affairs office rough estimate (2011) there are more than 75 child headed households affected by HIV and AIDS. Since there is high practice of polygamy, marriage inheritance and the religious influence in using RH services in general and particularly condoms during sexual intercourse, the number may exceed from the above figure. Among these children headed households 15 are purposely selected for this research study. These children headed households has been selected from Kibet and Alkeso administrative towns in which most HIV infection prevalence rate is estimated to be high since these towns are found along the main high way. The other main reason is that there are traditional annual religious ceremonies; night markets and dances which most people practice unsafe sex in these towns that leads to HIV infection.

1.8. OUTLINE OF THE STUDY

This dissertation is organized into five chapters. **Chapter One** deals with the introductory part of the research including the background and purpose of the research, stating the problem and problem statement, research questions and the general and specific objectives of the study and definition of terms, concepts and theoretical approaches. In discussing the relevant concepts, efforts are made to review the explanations and definitions that are given for the ten important concepts: ‘child’, ‘household’, ‘orphan’, ‘HIV/AIDS’, child affected by HIV and AIDS, grief, mourning, bereavement, ‘child household head’ and ‘poverty and being an orphan’.

In the theoretical approach section theories on child development focusing on children between 12-18 years is discussed. More specifically, the psychosocial theory on child development as described by Erik Erikson together with the debate over the issue of adolescence in the African context form the central theoretical orientation point for this study.

Chapter Two reviews the available literatures on the impact of HIV/AIDS on child household heads, the impact of the AIDS-epidemic on trends of orphaning in Sub-Saharan Africa, impact of HIV and AIDS epidemic in Ethiopia; and formation of child household heads: Underlying Causes, Child Household Heads: Challenges and Consequences; and the social support mechanisms; and Child Rights and Legal Frameworks that are available to address the challenges of these households.

In **Chapter Three** the research methodology employed for the research is outlined and **Chapter Four** focuses on the data analysis and interpretation that are gathered from the field study. Finally, **Chapter Five** centers on conclusions and recommendations based on the analysis and the general content of the study. The interview guides and informed consent forms are available in the appendix of this study.

CHAPTER TWO

REVIEW OF THE LITERATURE

The notion of impact in the field of HIV/AIDS is often used to show the scale of the crisis the AIDS epidemic brings about in all spheres of development – including individual, household and community level. Indeed, it has been over 30 years since human beings – mostly in sub-Saharan Africa – have been suffering from the impact of HIV and the consequences of the AIDS epidemic. The effects of HIV/AIDS are numerous but this chapter specifically surveys the impact of HIV/AIDS on child household heads and the social support mechanisms that exist in response to ensure the well being of these households.

Globally, 34.0 million (31.4 million–35.9 million) people were living with HIV at the end of 2011. An estimated 0.8% of adults aged 15-49 years worldwide are living with HIV, although the burden of the epidemic continues to vary considerably between countries and regions(Global Report 2012: 8)

The number of people dying from AIDS-related causes in sub-Saharan Africa declined by 32% from 2005 to 2011, although the region still accounted for 70% of all the people dying from AIDS in 2011 and 90% of children dying from AIDS(Global Report 2012: 12)

2.1. The Impact of HIV/AIDS on Child Household Heads

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

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

Historically, large scale orphaning has been a sporadic, short term problem caused by war, famine or disease. However, the AIDS epidemic has transformed orphaning into a long-term chronic problem that will continue at least through the first third of the twenty-first century

(Hunter and Williamson 2000:1). The extensive death of adults, partly due to AIDS, in Africa is producing orphans on a scale unprecedented in world history. Without AIDS, the total number of orphans in sub-Saharan Africa would have declined between 1990 and 2010. HIV and AIDS, however, will push the number of orphans in the region to more than 53 million by 2010 (UNICEF 2005).

In 1990, from the total of 30 million orphans in the Sub-Saharan African region, the AIDS epidemic accounted for only 1% of orphan children. However, from 1995 onwards there has been a significant increase of orphan children due to AIDS related parental deaths. With HIV/AIDS, if one parent is infected with HIV, there is a possibility that the other is or will become infected and that both will eventually die of AIDS. This means that there will be disproportionately large numbers of double orphans as the epidemic advances, signaling that the pattern of orphaning is shifting and the number of double orphans is increasing.

Ethiopia – similar to many countries in sub-Saharan Africa – faces the reality of a large (and growing) number of the population under the age of 18 years (MYSC 2004:1). The reality that Ethiopia faces is a population with high numbers of children and added to that the challenges of poverty, high rates of AIDS-related parental deaths and the resulting large number of orphans. The AIDS epidemic is one of the leading causes of parental death in Ethiopia which leaves thousands of children orphaned. In 2003, Ethiopia attributed 539 000 of children orphaned – or 12% of the number of orphans in that year – to AIDS-related parental deaths (AIDS in Ethiopia 5thReport Fact Sheet 2003:3). In the ensuing years, this figure increased significantly to AIDS-related parental deaths accounting for 15% of orphaned children (or 744 100 from a total of 4 885 337) in Ethiopia in 2005 (Federal Ministry of Health/National HIV/AIDS Prevention and Control Office 2007:25). These figures indicate the rising numbers of AIDS orphans in Ethiopia.

Additionally, some studies in Addis Ababa, the capital of Ethiopia have indicated the collapse of certain indigenous social support systems such as care from elders who are unable to withstand the financial crisis that resulted from AIDS-related mortality (Pankhrust and Hailemariam 2004: 35-58). The rising numbers of AIDS orphans coupled with the collapse of

indigenous social support systems may result in a considerable number of orphans being child household heads.

2.3. Impact of HIV and AIDS epidemic in Ethiopia

Next to poverty, HIV/ AIDS is the second most important triggering factor of the orphan crisis in the country. HIV/AIDS is the number one cause of parental death in Ethiopia and continues to leave millions of children orphaned. According to UNAIDS' 2006 report on the global AIDS epidemic, in 2005 there were around 134,000 AIDS-related deaths in Ethiopia, or 67 percent of the total figure for sub-Saharan Africa in that year. A considerable number would have left orphaned children behind.

According to Global report in 2005, Ethiopia counted a total of 2.4 million maternal, 3 million paternal and more than 600,000 double orphans, making the country home to the fourth largest orphan population in sub-Saharan Africa after Nigeria, Democratic Republic of Congo and Zimbabwe. A considerable number of double orphans are likely to end up as unaccompanied child-headed households. In 2005, Ethiopia was home to more than 77, 000 unaccompanied child-headed households; the second highest figure in sub-Saharan Africa below only Zimbabwe.

In addition, in 2005 Ethiopia had 530,000 children who lost their mothers to HIV/ AIDS and 465,000 children who lost their fathers to HIV/ AIDS. The majority of these children are likely to live with an incapacitated father or mother, leaving them as virtual heads of their households.

According to the 2005 Demographic and Health Survey, 46 percent of primary caregivers make arrangements for someone else to take care of their children in case of their own inability. That means the remaining 54 percent of caregivers leave children to fend for themselves in case of incapacity, and are likely to rely on their children for their own needs.

By 2011, Ethiopia had around 225,000 child-headed households, or a staggering 675,000 children growing up in the care of siblings without the company of adults (UNAIDS 2011).

At continental level, most of the existing data on child-headed households is outdated. This limits its value in informing programs in the face of Africa's fast changing circumstances.

Most of the information on child-headed households in Ethiopia is also embedded in literature relating to orphans and vulnerable children in general. The lack of information on the subject masked the specific nature of the challenges facing child-headed households, as well as the special support they need, and their plight has not been sufficiently appreciated by policy-makers and advocacy groups(The African Child Policy Forum 2008: 8).

Due in large part to the paucity of knowledge on the subject, there have been limited efforts to influence legislation and social welfare structures related to child-headed households. As a result, children in child-headed households remain legally excluded from healthcare, education and other support systems because in most cases the presence of an adult in a household is required to allow legal claim of services. These children have often also been victims of property grabbing or groundless claims on inherited land and/ or houses by opportunist adults in the community, as they do not have the legal status to defend their rights. (The African Child Policy Forum; UNHCHR 2006).

Children who chose not to be integrated into relatives' households refused because they feared abuse, wanted siblings to stay together as one family or to keep the promises made to dying parents. Some wanted to keep inherited property, land, housing or small amounts of money from their parents rather than move in with relatives. (African Child Forum 2008: 12).

Child-headed households in Ethiopia faced tremendous emotional and psychological challenges and lived with the constant memory of their deceased parents and their lingering agony and death. The majority of children suffer from feelings of loneliness, desperation, traumatic stress following bereavement and stress associated with shouldering an adult role at a young age, low self-esteem, fear, and a sense of alienation(African Child Forum 2008: 14). A substantial number of girls heading households and their female siblings faced rapes or attempted rape on numerous occasions.

2.4. Formation of Child Household Heads: Underlying Causes

In the past 25 years the AIDS epidemic has left the world, especially sub-Saharan Africa, with increasingly diverse types of household structures such as large households with unrelated

fostered or orphaned children attached and cluster foster care – where a group of children is cared for formally or informally by neighboring adult households. Today, sub-Saharan Africa faces large and growing numbers of child household heads due to HIV/AIDS and other factors such as armed conflict and grinding poverty.

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

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

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

These family networks will continue to be the central social welfare mechanism in most countries. However, as the number of orphans' further increases over the coming decade and an ever larger number of adults is infected and affected by HIV/AIDS, many of these family networks will face even greater burdens. In support of this, it is found that among the extended family the burden of caring for orphans or family members ailing from AIDS falls disproportionately on grandparents, many of whom suffer from poverty and poor health themselves (UNAIDS 2007:92). There is also an indication that there is 'huge variation in

living conditions experienced by these children, and it still leaves millions of children being cared for by strangers – or by no one’ (Ibid.:92). Hence, this traditional support system will fall under severe pressure since it is overstretched by the additional resources needed to support an ever growing number of orphans (Mahati et al 2006:2).

Now, the fact seems to be that neither new nor conventional formal and informal care systems have been able to cater to the needs of the millions (and growing number) of orphans and vulnerable children. When all these options of care fail, children will have no choice but to establish their own household with the eldest often taking the headship.

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

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

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

Thirdly, children may establish their own child headed households out of fear of being mistreated or exploited in foster families. This fear is not unsubstantiated as a study in Tanzania showed that 50% of the foster parents accepted orphans because they wanted to employ them as domestic workers (UNICEF 2006:30). There is also some evidence that orphans may experience discrimination within the household. One recent study in Mozambique documented discrimination in allocation of resources in poor households against children who are not direct biological descendants of the household head (Ibid. 13). Qualitative research carried out in Malawi and Lesotho found that children who had migrated to another household and also experienced the death or sickness of a parent reported being given different food from other children in the household, being beaten and overworked, and having received inadequate clothing (Ansell and Lorraine 2004:3-10). One recent study found that orphan children in Ethiopia are being ostracized by their communities and exploited financially by relatives who had taken them in (ACPF 2008). A USAID research report came to a similar conclusion: ‘denied basic closeness of family life, children lack love, attention and affection - they are often harshly treated or abused by step- or foster parents’ (Hunter and Williamson 2000:4).

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

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

2.5. Child Household Heads: Challenges and Consequences

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

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

Moreover, orphans are more likely than other children to be excluded from essential social services such as education. The first study in Uganda indicated that the education of adolescents living with and caring for a terminally sick parent may suffer more than that of fostered orphans (Gilborn et al, 2001). In a second study in Kenya, (Yamano and Jayne, 2005) adult mortality negatively affected schooling in the period directly before mortality occurred – most likely, they surmise, because children are sharing the burden of caregiving. Studies from Zimbabwe, Tanzania, and Ethiopia have found that orphans are at risk of being excluded from family care and, instead of attending school, becoming street children or victims of exploitative labour (UNAIDS/UNICEF 2004:15). Even among orphan children themselves, double orphans are more disadvantaged than single orphans. In Tanzania, the school attendance rate for children whose parents are alive and who live with at least one of them is 71%, but for double orphans it is only 52% (Ibid.).

The primary obstacles to the provision of adequate care of orphans are thus not sociological but economic. Fostering households will need a wide range of material and non-material support systems to help them cope economically and socially (Adato et al., 2005). These needs will

only be exacerbated by the rapidly increasing numbers of orphans that will put this traditional system under severe stress over time.

Any approach to strengthening the capacity of the extended family to cope with the extra burden of an orphaned child needs to be cognizant of any other stresses and sources of vulnerability that may be simultaneously affecting the household and the child.

The inability to fulfill material needs (such as household goods and money to pay for essential needs) is the one inescapable reality for households headed by orphan children. This is confirmed by recent studies in Malawi, Rwanda, Zambia and Zimbabwe where it was found that households headed by orphan children are worse off with regard to possession of basic material goods (a blanket, shoes and an extra set of clothes) compared to other children (UNICEF 2005:13). A situational analysis of orphans and vulnerable children in four districts of South Africa produced similar results where material needs were cited as the highest priority for households with orphans, and finding the money to pay for essential needs was the greatest constraint (Davids et al 2006:ix-xi).

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

while only 3% of non-orphans expressed such feelings (Benjamin, Cantor-Graae and Bajunirwe 2005: 555-564).

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

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

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

2.6. The Social Support Mechanisms

In many sub-Saharan countries, HIV and AIDS, in its earlier days, has been considered solely as a health problem and the social support mechanisms have overwhelmingly focused on prevention strategies. Today, the multidimensional impact of HIV/AIDS are widely recognized and governments, civil societies and others have made efforts to challenge the impact of the

epidemic by setting different mechanisms in place –such as impact mitigation strategies. This section surveys the existing social support mechanisms that are available to address the challenges of orphan households. Most importantly, it investigates the role of civil society to promote the wellbeing of orphan households to cope with the challenges they face together with the legal frameworks for the protection of orphan children.

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

‘**Civil society organizations**’ refers to a broad group of institutions and actors including, but not limited to, community based organizations, non-governmental organizations, think tanks, social movements, religious organizations, women’s rights movements, grassroots and indigenous people’s movements, and voluntary organizations (UNICEF 2005:72).

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

Service delivery approaches through the public sector or NGOs may work in urban and peri-urban areas, but are costly and hard to scale for widely dispersed rural populations. Community driven approaches that build on existing community structures such as self-help groups, women’s groups, and church groups, offer great potential (Nyambedha, Wandibba, and Aagaard-Hansen, 2001). Based on their research in Tanzania, Urassa et al. (1997) have suggested that as the number of orphans increases, communities will not have to develop

radically different coping mechanisms. The challenge, and probably the only feasible intervention, they argue, is to develop community-based support systems that focus on the most vulnerable households and extended families, using only limited external support. Citing experience from community-driven approaches to other development challenges, Binswanger et al. (2005) concur – communities could be provided with the training, facilitation and financial means to manage the basic social protection activities of the vulnerable families in their midst, with such efforts being coordinated at the local level.

Community-driven development has unique advantages: it is well placed to respond to the demands for local information and knowledge, resulting in locally appropriate responses. Such local knowledge, rather than generic standards imposed from elsewhere, better addresses questions on who is vulnerable and what the major forms of vulnerability are. Externally derived responses may be viewed by community members as inappropriate if they undermine existing coping mechanisms and may not be sustainable for this and other reasons. Intervention planning must therefore take into account existing norms and practices and seek to strengthen family and community capacities to protect and care for vulnerable children.

Community-driven development is designed to maximize community capacity and involvement, but this does not imply that communities would be left without support. Though many community initiatives are established without external facilitation, they can be strengthened by involving external allies. Partnerships between community groups and outside organizations offer great potential for developing sustainable, effective and scaled-up responses to the needs of children affected by HIV and AIDS (Foster, 2002).

2.7. Rights and Legal Frameworks

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

2.7.1. Review of Existing International Declarations, Conventions and Covenants

The government of Ethiopia enacted most of the international declarations, conventions and covenants. The Convention on the Rights of the Child and the African Charter on the Rights

and Welfare of the Child give primary consideration for survival, development, protection, non-discrimination, participation and the best interest of all children, including OVC.

2.7.2. International Convention on the Rights of the Child

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

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

Moreover, the CRC give due emphasis to the protection of children from all forms of exploitation and abuse including protection from substance and drug abuse (Article 33), economic exploitation (Article 32), sexual exploitation (Article 34), child sale and trafficking (Article 35), emotional and physical abuse and punishment (Article 37). The state has to work towards protecting children from performing any work that is likely to be hazardous or to interfere with their education, or to be harmful to their health, physical, mental, spiritual, moral and social development (Article 31).

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

The Africa Charter on the Rights and Welfare of the Child (ACRW) also recognizes the holistic rights of children. The constitution of Ethiopia gives special protection and assistance to orphans and vulnerable children. The Africa Charter on the Rights and Welfare of the Child in Article 20 states the responsibilities of parents and other legal responsible duty bearers to ensure that the best interests of the child are paramount at all times; to ensure, within their

abilities and financial capacities, conditions of living necessary for the child's development and to ensure that domestic discipline is administered with humanity and in a manner consistent with the inherent dignity of the child (MoLSA and UNICEF 2005).

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

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

- To assist parents and other persons responsible for the child and in case of need to provide material assistance and support programmes particularly with regard to nutrition, health, education, clothing and housing;
- To assist parents and other responsible parties of the child in the performance of childrearing and in ensuring the development of institutions responsible for providing care of children.

In general, international legal frameworks recognise all the rights and welfare provision guidelines of vulnerable children. However, realisation of these rights, including survival and development, depends upon the economic development of member nations. If there is not the necessary national capacity to preserve these rights of children, the state can call for resources from the international community. Regarding the responsibility of the state to allocate resources, CRC (Article 4) depicts that 'States parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international cooperation'. Similar to the convention, allocation of resources to promote the welfare of orphan and vulnerable groups is not mandatory in the context of the constitution of Ethiopia. It is stated as: 'The state shall, within available means, allocate resources to provide

rehabilitation and assistance to the physically and mentally disabled, the aged, and to children who are left without parents or guardians' (FDRE 1995:17).

2.7.4. Review of Existing Ethiopian Laws and Policies Regarding Children

Ethiopia has adopted laws that protect children against the violation of their fundamental rights. The adopted laws guarantee access to information, education, health services, and other social services ensuring their rights of inheritance, and protect them against sexual abuse. These laws, in addition to the constitution of Federal Democratic Republic of Ethiopia (FDRE), are found in the Revised Family Code of Ethiopia, the Penal and Civil Code of Ethiopia, and other legal instruments. For example, in the context of the Family Code of the FDRE, the father and mother are the core tutors and guardians of their children. Parents are also responsible to appoint through a will, the guardian or tutor of their minor after his/her death. In the absence of the appointment of a caregiver and when children lost their parents, the family code devolves the function of guardianship to relatives of the child in order of importance. The first responsible guardians are ascendants of the child. In their absence, the brothers or sisters of the child who attained majority are the next responsible persons to nurture the child and in default of siblings, the uncle and aunt have legal accountability to care for the child (FDRE 2000). According to this code, the role of relatives for the foster of orphan and vulnerable children is very important.

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

With regard to OVC, Ethiopia has also enacted the National HIV/AIDS Policy in August 1998 even though it was years after the first cases of AIDS were reported in Addis Ababa in 1986 (Laster et al 1998: 139). The adoption of a special policy on HIV/AIDS arose out of the realisation that the HIV/AIDS poses a serious threat to the viability of the country. While the policy emanates from ‘the need for a concerted multi-sectoral effort in controlling the spread of HIV and mitigating the impacts of AIDS’, it also underscores the need for ensuring and protecting the wellbeing and rights of OVC (MoH 1998). Article 2.4 stresses the need for proper institutional care; home and community based health care and psychosocial support for PLWHA, orphans and surviving dependants. The policy also encourages efforts for provision of care and support for children orphaned when one or both parents die of AIDS. Ideally parents shall get proper counseling to ensure clear arrangements of suitable options to be made among extended family for community support for their children before death (Article 6.8). Equally important is that the policy prohibits discriminatory practices against OVC. Article 8.4 underlines the fact that ‘...orphans shall be treated in a manner similar to other members of the community with the same access to educational programmes, serological testing, inpatient and outpatient care and shall not be subjected to discrimination practices on the basis of HIV/AIDS’.

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

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

Summary of the Main Themes

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

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

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

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

In sum, Ethiopia has plenty of laws and policies regarding children on paper. Ethiopia is the first to adopt and sign international laws, but the problem is the enforcement of laws and policies. Adopted laws and formulated policies do not have strategies and guidelines for how they are implemented.

CHAPTER THREE

STUDY DESIGN AND METHODOLOGY OF THE RESEARCH

3.1. Research Design and Methodology

This study is a qualitative study by design whereby pertinent information in relation to the topic of the study have been gathered from primary sources using ‘purposive sampling’ procedures. The study is based upon fieldwork consisting of interviews with child household heads affected by AIDS, their siblings and key informants from the woreda women and children affairs office and Aynage Child and Family development organization. In this study respondents will be referred to as ‘*participants*’. The field study has been conducted over a period of 5 weeks commencing from December 2013 to January 05, 2014 taking into account children’s time.. Since the study is exploratory research, the following data collection methods were employed: unstructured (face to face) interviews, focus group discussions, observation schedule, semi-structured interview, document analysis; and key informant interviews. Primary data has been collected from 15 households – 8 households from girl child heads and the remaining 7 from boy child heads - headed by children using the life story research method Focus group discussions has also been held among siblings of the 15 identified households separately in two rounds. In the first round 8 children (5 girls and 3 boys) and in the second round of the focus group discussion the remaining 5 children (3 girls and 4 boys) have been included. Using the semi-structured interview method, the study has gathered evidence from three key informants drawn from the local institutions, government institutions and NGOs on the support mechanisms that existed for such households and the perception of key informants regarding the problems of child household heads affected by AIDS. During the interview a tape recorder has been used to avoid losses of memory and to quote exactly what children is said. Field notes have also been taken of the responses of the participants during the interview. The researcher has been used local language translators in the research process (Siltigna Language speakers) to make the conversation with research participant children friendly and to grasp the required information easily and in-depth.

3.2. Sample and Sampling Technique

The study shall employ a ‘**purposive sampling**’ method. The life story research that this particular research took up called for such a sampling method. The selection of these households – both the face-to-face interview and focus group discussion – is purposive taking different attributes like age and gender into account. With this in mind, the samples in the research will be selected from both sexes within the age range of 12-18 that are enrolled in school (such as siblings in FGD) as well as those dropped out (child household heads) in order to provide for their household a means of survival. In terms of economic status the research mainly will focus on those who are found in the lower income level. According to the woreda women and children affairs office rough estimate (2011) there are more than 75 child headed households affected by HIV and AIDS. Since there is high practice of polygamy, marriage inheritance and the religious influence in using RH services in general and particularly condoms during sexual intercourse, the number may exceed from the above figure. Among these children headed households 15 are purposely selected for this research study. These children headed households has been selected from Kibet and Alkeso administrative towns in which most HIV infection prevalence rate is estimated to be high since these towns are found along the main high way. The other main reason is that there are traditional annual religious ceremonies; night markets and dances which most people practice unsafe sex in these towns that leads to HIV infection.

The list of the research participants will be available from woreda women and child affairs office and also in those NGOs working in the area. Prior to the interviews, appropriate meeting times will be scheduled according to the time schedules of the children who agreed to the interviews.

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

talk about their lives, but when a researcher gets into details of life history, he/she quickly touches a lot a nerves’.

3.3. Tools for Data Collection

According to Roche 2009, choosing appropriate tools and methods depends on the purpose and focus of the assessment, its context, the capacity and skills of those involved in and the resources available. One of the major skills needed is the combination and sequencing of tools and methods. The major instruments of data collection to be used for this research are semi-structured questionnaires- interview schedule, observation guide checklists, and FGD.

3.3.1. Interview Schedule:

Unstructured (face-to-face) interview

Primary data shall be collected from 15 households – 8 households from girl child heads and the remaining 7 from boy child heads - headed by children using the life story research method. The life story mainly will focus on these household heads as these children are the main targets of the research. Using the interview guide, I will collect qualitative information in face to face interviews by going directly to the homes of child household heads. During the process, I will be part of their world as much as possible. The interview shall take 45 minutes on average.

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

3.3.2. Focus Group Discussion schedule

Focus group discussions shall also be held among siblings of the 15 identified households separately in two rounds. In the first round 8 children (5 girls and 3 boys) and in the second round of the focus group discussion the remaining 5 children (3 girls and 4 boys) will draw from the households headed by children. The aim of these discussions is to see the nature of hierarchical relationships that existed in the household, the general relationships between brothers and sisters and conflicts of household management in order to attain a wider picture of their day to day life. The focus group discussions will take 60 minutes on average and since research participants will spend more time with the researcher, the researcher will pay transportation and lunch allowance for each participant. Additionally efforts will be made to create a relaxed environment (making comfortable seating arrangements and telling stories and jokes) for children to share their experiences freely.

This data collection tool is selected because of its advantage in acquiring deeper understanding and gathering detailed information from the target groups regarding the issue under investigation. This is believed to help in getting detailed information about the household power dynamics and the inner feelings of these siblings because being in a group with others that have similar issues to discuss, may give confidence to speak about their experiences in a way which may not occur in one-to-one interviews (Young 2004: 34-58; Goode and Hatt 2006:313-41; Bernard 2006).

3.3.3. Semi-structured interview

Using the semi-structured interview method, the study will gather evidence from three key informants drawn from the local institutions, government institutions and NGOs on the support mechanisms that existed for such households and the perception of key informants regarding the problems of child household heads affected by AIDS. In addition to the semi-structured interview being undertaken with the informants, available data relevant to the subject shall be gathered and analyzed. These institutions are selected they are considered one of the robust organizations who are providing holistic care and support services to OVC for many years.

This will help the researcher to triangulate issues and to gather the relevant information for the study.

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

3.3.4. Observation schedule

In order to have better understanding of the roles, experiences and challenges of child headed households affected by HIV/AIDS, the researcher will use critical observation as a data collection tool in all the research process. Critical issues will be taken note of through direct observation, such as observing the physical condition of children, hygiene, communication among siblings and with neighbors, their sense of self-confidence, anxiety(if any), schooling and many other issues.

3.3.5. Document analysis

The researcher will assess the secondary sources concerning any support given by different local and government institutions and NGOs for these child headed families and the effort taken to curb the problem.

3.3.6. Data Analysis Strategy

The researcher will assess the secondary sources concerning any support given by different local and government institutions and NGOs for these child headed families and the effort taken to curb the problem.

There is growing interest these days in the analysis of qualitative data (Bernard 2006:463). Qualitative data analysis is an iterative process (Strauss and Corbin 1990:68) by which a researcher may study transcripts of the data in order to understand the relevant aspects. A well

tested method in analysis of qualitative data is what Bernard (2006:492) calls ‘memoing’ which entails keeping continual notes about the coding and new directions of the research. Inductive or ‘open coding’ allows understanding to emerge from studying the texts (Ibid:493). It means that highlighting some of the words or phrases a researcher thinks might be important may turn into themes. In fact, Strauss and Corbin (1990:68) recommended explicitly using actual phrases of the text – the words of real people – to name themes, a technique they call *in vivo coding*. Milles and Huberman (1994:56) say simply: ‘coding is analysis’.

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

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

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

3.3.7. Ethical Considerations

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

skill and involves ethical considerations particularly from the point of view of the research participants.

In certain cases, participation of children in research becomes indispensable because information obtained from other individuals cannot answer the question posed in relation to children. To this end, I shall take into account thorough ethical considerations when gathering data from primary sources.

Studying children requires a researcher to obtain informed consent from the legal guardian or parent. The case of children in this particular research will be challenging since neither a legal guardian nor a parent is present to grant the researcher written permission. This is because; this study is targeted on those children who are living with no adults or extended families. The only option will be to obtain written permission from community workers who are regularly working with these children as guardians/caregivers and provide children with care and support services; and from woreda Women and Children affairs office. The permission process shall be finalized prior to the interview.

Once permission is granted, seeking consent from the participants will be followed. But, before seeking consent from the participants (child headed households and their siblings), the researcher shall inform them of all the aspects of the research that might have affected their willingness to participate and answer the participants' questions. Moreover, the researcher will also respect the participants' freedom to choose to participate in the research or not by giving the participants the opportunity to give or not to give consent to participation as well as to choose to discontinue participation at any time. Wherever appropriate, the researcher will provide the participants information about the planned research including the purpose of the research; the likely benefits of the research; the procedures to be undertaken and duration; and that participation in this research is voluntary and that the participant might have withdrawn from the research at any time;

The consent of respondents shall be recorded when taping the interview. Participants of this particular research will be told that they have been granted no special incentives for partaking in the research; and the researcher will keep all the information obtained from the research

participants as confidential. The participants' identity shall be concealed in written and verbal reports of the results.

CHAPTER FOUR

DATA ANALYSIS AND PRESENTATION

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

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

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

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

Children have often assumed parental responsibilities during the illness of their parents and continued this role after the death of their parents in many countries in sub-Saharan Africa. There has also been an indication that children could make a choice to establish their own households: they may not want to be separated from their siblings and go to an orphanage; for fear of mistreatment and abuse by relatives; and when they have decided to stick together to fulfill promises to their deceased parents.

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

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

This section specifically analyses aspects pertaining to the reflections of the child household heads in the study on the roles they have such as assuming parental responsibility, their perception of taking on these responsibilities and the leadership strategy they have used in managing the household. It also analyzes stories of the child household heads on the challenges they have faced, the coping strategies they have used to ease their grief and pain, and their views on the future. Though the research gathered evidence from 15 selected child household heads, I often found similar responses relating to specific themes.

4.1.1. Reversal of roles

One of the experiences reported is having to adjust to the reversal of parental and child roles when a parent becomes ill. This experience presents vexing challenges. Under this sub-theme, the accounts provided reveal a range of emotions, including pain and hurt as well as loneliness and depression. These emotions are illustrated in the following extracts.

Interviewee # 1 gave the following answer to the question of *what life was like during the time that her mother was sick*:

“It was hard! We were used to (pause)...my mother was the only person that used to do everything herself...so when she became sick all this changed. We now had to do things for her. We had to wash her – we just had to do everything for her. That was very hard! (The interviewee had tears in her eyes).”

For this interviewee, memories of this time in her life were still filled with pain and hurt, as evidenced by the tears in her eyes as she described what life was like.

The change of roles represents a shift in dependence between parent and child. Interviewee # 10 not only realized this fact but also found it very hard to accept. The experience induced feelings of intense loneliness and depression as well as suicidal tendencies:

“It was difficult because she was ill and I was all alone...I also had to be with her all the time because she always wanted me next to her all the time. At the time my younger sibling was about one year old. I had to look after everyone. I really felt so small at the time. I felt like I could just kill myself... (The interviewee took a long pause).”

The despair and panic is apparent from the above extract. The suicidal ideation points to feelings of exasperation and complete helplessness to avert what was happening. Her life and world, as she knew it, must have appeared to be crumbling and falling apart right in front of her eyes.

4.1.2. Living with parental illness

Apart from and in conjunction with the reversal of roles described above are the effects that living with parental illness held for some respondents. Interviewee # 4 below describes the adverse effects related to school performance or attendance; and the events around the time of her mother's illness. She provides a very clear account of how her mother's illness impacted on her ability to attend school as well as pay attention in the classroom:

“At the time my mother was ill I could not attend school...I had to interrupt school on a daily basis just to look after her. She was HIV positive and she had or there is a small child at home...all this made it hard for me to concentrate at school...I just could not concentrate at school. When I was at school I would worry about her. I was just not coping at all. I even failed in grade seven.”

What is most apparent from the above response is the anxiety that the respondent experienced during this period. The fact that she struggled to concentrate reveals how worried she was about her mother's condition.

It appears as if she felt a sense of shame regarding her mother's illness. She did not want her teachers to know the real reason behind her inability to attend school regularly or worsening academic performance. The respondent mentioned later during the interview that she failed grade seven during this time:

"I had to move in and out school very often and whenever my teachers would ask to see my parents I would always make up excuses. I would tell them things like that my parents stay far away or they are not around - just anything to prevent them from coming over. Whenever they asked where I stayed I would give wrong and different addresses each time just to stop them from coming over."

The sense of shame and the need to keep her mother's illness a secret may have been related to her mother's HIV positive status. In fact, she mentioned later in the interview that she was the only one that knew her mother's status. Even her older siblings, who were not staying with them during the time of her mother's illness, were unaware of their mother's illness. The interviewer was unable to establish whether the secrecy was something that her mother wanted and encouraged.

For interviewee # 9, the thought of his mother's illness was persistent and obsessive at some point after his mother's death:

"I remember that, you know, many times before I went to sleep I would always think about my mother. I just could not stop thinking about her. I just could not stop thinking about how sick she was. Hugh!" (The respondent looked very sad at this point).

The above extracts illustrate the debilitating effects of parental illness, especially HIV/AIDS-related illness, on the daily functioning of these interviewees. The constant worrying had very negative consequences for the fourth interviewee's school performance. The interviewee struggled to maintain regular attendance at school. Yet, even when she managed to attend, she had difficulties concentrating in the classroom. In the end, she failed in grade seven.

Exacerbating her problem was the sense of shame and the fact that she wanted to avoid her teachers finding out about her situation at home.

With interviewee # 9, the thought of his mother's illness became obsessive. He mentioned that he would always think about how sick his mother was every time before he went to bed and these thoughts could possibly have affected his sleeping patterns.

4.1.3. Denial and fear of impending reality

With the increasing illness and incapacitation of the parent comes a fear of the impending reality. As illustrated in the next extracts this point to the fear of the meaning of the loss itself as well as the implications of the loss, i.e. uncertainties around future prospects:

"I was very scared because I could see that she was going to die. I was scared of what was going to happen to us after her death (There was a long pause at this stage. The interviewee also cried)." (Interviewee # 2).

"The question then was: What are we going to do because it looks like our relatives are not going to take care of us. I was just confused and didn't know what I was going to do." (Interviewee # 7).

In seventh interviewee's case, the absence of support from the people whom she thought would provide it, i.e. her relatives, made matters even more difficult during this period.

4.1.4. Grief and sense of loss

One of the emotions felt acutely was grief and a sense of loss. Although not always articulated explicitly, it was nonetheless evident in various interviews.

The way in which participants respond to loss differed from respondent to respondent. The interviewees also revealed that while some respondents had to deal with their own grief and sense of loss, they also had to cater for what their siblings were going through emotionally with very little outside support:

"Back then it was very difficult for my sister because she would cry every night...she would complain about missing our mother and stuff...this I would say was very tough for me (Interviewee cried at this point)" (Interviewee # 1).

The following extract also paints a vivid picture of this dire situation. The extract depicts interviewee seven's response to the question as to how she thought her brother was coping with

the fact that it was just the two of them at home. In her response, the respondent focuses on the impact that losing their mother had on her younger brother:

“My brother would isolate himself quite a lot. He did not want to go out or do anything for that matter. He just did not want to believe. It was almost as if the whole thing was not real for him”

Later on, she describes how this affected her:

“It was very painful. I think he made things very painful for me because whenever I looked at him...I mean he was not like that. He wasn't like that before. So, I had to think of him and what he was going through in addition to the concerns I had on what was going to happen to us. I was also badly affected because I could not stop thinking about my mother as well.”

The fact that respondents had to deal with what their siblings were going through emotionally on top of their own grief and concerns about the future complicated matters only further.

4.1.5. Lost childhood and self

One of the significant issues that emerged from the texts relates to lost childhood and self. For some of the respondents, this issue captures feelings around having to assume responsibilities of an adult when they still consider themselves children. It also includes a sense of deprivation and exclusion from developmentally appropriate activities, i.e. participation in activities that other children of their age are involved in.

The following extract depicts third interviewee's response when asked to describe what it meant for her to carry responsibilities at home:

“I feel that my childhood has been taken away from me. I am now not only a child but 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 when they come back from school they do their home work. I mean, who does that at my age? People at my age want to do their own stuff.”

Interviewee # 4 had something similar to say when the same question was posed to her:

“Being responsible at home is tough you know. Seriously it is tough. You know there are things that you think you can do...I am only human. I’m still a child after all. I still 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. When you have money you do not enjoy it like other children your age because you constantly have to think about the situation at home. You know your parent’s house is now like your own...when people ask about the mother of the house they are actually referring to you.”

Both extracts express very strong views and feelings on the subject. The accounts present lucid snapshots of the suffering and the pain endured as a result of losing one’s childhood from having to assume adult responsibilities at an early age.

Interesting is the somewhat contradictory, although optimistic, view that interviewee # 3 later expressed regarding her situation:

“In the beginning it was very difficult adjusting from being a kid to looking after other kids. But after a while you get used to it because it is like ‘okay so this is what I must do’ and ‘this what I must not do’. You just get used to it. It is difficult, though, because on the one hand you have to be a child and on the other hand you also have to be a mother and mentor to the other children. It is difficult but then you can deal with it.”

The above extract suggests a certain degree of adjustment, especially from the practical point of view, i.e. the practical things that need to be done when running a household. It does, however, not imply acceptance of the role, particularly from an emotional point of view.

Interviewee # 3 seems to recognize the conflicts inherent to the role. It appears as if the role for her entails or requires adjusting and living with two divergent identities, i.e. being both child and mother.

4.1.6. Sense of obligation to family

In combination with the loss of childhood and self, some of the respondents revealed a feeling of obligation to the family or siblings. What is interesting about this issue is that while there is a sense of feeling aggrieved by what life had thrown to them, there is also a strong feeling of responsibility and obligation to the younger siblings. The following three extracts serve as

examples. Although short, it paints a very lucid picture of the seriousness with which he views his responsibility:

“The first thing that is of concern for me is her happiness (the interviewee’s younger sister) instead of mine. It is the most important thing at this point in my life.”

This is what another interviewee had to say: *“there are six of us at home. There are four boys and two girls. I am the oldest girl. When it comes to the boys in the family...well boys will always be boys. They don’t take things seriously. When one of them has money he won’t bother with the rest of us. In my case, I have to think for the others. What they eat is a concern of mine.”* (Interviewee # 5).

The next extract is interviewee twelve’s response to a question aimed at getting a sense of how she sees herself in comparison to other children that are not in her situation:

“It is different for me because I have to think for my younger sibling all the time. Finishing school is important for me because at least with an education I will be able to continue looking after my sibling.”

It is apparent from these three extracts that the respondents are driven by a sense of duty and the need to close the gap left behind by the death of their parents as best as they can. This is also complimented by a feeling of compassion for their siblings.

4.1.7. Sense of abandonment and neglect

This sub-theme focuses on experiences of abandonment. It transpired during the interviews that some interviewees felt a sense of abandonment, especially from people that they expected support from, such as relatives. Interviewee # 5 displayed visible signs of anger and disappointment when she spoke about the lack of support from relatives:

“My aunts are only concerned about their own children. They don’t bother to care if you are not their biological child. When they ask about my siblings whenever I see them I always tell them that they are all right. Even when they offer to buy bread for us I always refuse their help. I don’t want their money because they don’t care. They were only with us during the funeral

and left soon after. When they left they did not bother leaving us some money for food or for my younger sibling's crèche tuition. We had to find means to raise the money. I don't put them anywhere."

Interviewee # 5 feels a great deal of disappointment. It appears as if she may have expected her aunts to play a significant role in their care in the event of her mother's death. In her case, the anger also emanates from a feeling that neither she nor her siblings are as important to her relatives as their own biological children.

Furthermore, she is angered by what appears to be a family dispute that she and her siblings are caught in middle of:

"There has always been this rumor that my step grandmother has a bad heart. You know things like that. My aunts don't like her. I used to stay with her and I am still very fond of her. I think my aunts are just being irresponsible. They have no interest in what we eat or how we sleep..."

The influence of unresolved family disputes on present circumstances was also an issue for interviewee # 6. In her case, the dispute was between her father and her mother's family. Although it could not be established clearly during the interview, the issue involved may originate from unsettled dowry negotiations:

"My father's family does not get along with my mother's side of the family. They claim that my mother's family is uncaring and they say bad things about my mother. My mother and father were supposed to marry...those things have nothing to do with me. These things do affect me because these two people to me are one person."

What emerges from the two extracts is the role of complicated unresolved family disputes and histories in the interviewee's current predicaments. This, in turn, has resulted in the respondents feeling neglected and deserted.

For interviewee # 10, the feeling of abandonment is heightened not only by the lack of assistance and involvement by her relatives but also by the negative things that her relatives are saying about the way in which she cares for her siblings:

“They (the respondent’s relatives) are not helpful at all. They don’t visit and they talk about me with other people. They say that I don’t look after my siblings...it feels bad because the way I see it that they don’t love me. At the moment, I really do need the love of an adult that I am related to.”

4.1.8. Concern over survival

Probably the most commonly cited concern is related to survival. The issue focuses specifically on how the respondents survive in the absence of parents or adults.

This sub-theme focuses on the effect of economic disadvantage and financial hardship on the relevant respondents’ experiences. The various manifestations include anxiety over a number of issues, such as food, clothing, school fees as well as having electricity at home. The next extracts demonstrate these concerns:

“Yes we do run out of food. Last weekend we did not have food and it looks like we won’t have food this week either (Interviewee # 4).

“You know because I am the oldest at home at the moment, when we do not have bread and my younger sibling is hungry I have to think of something. You know if my mother were still alive I would not have to worry or be responsible for these things because I would be looking at her to provide for us.” (Interviewee # 6).

“Even when you have an opportunity to do something at school or even just enrolling, one needs money to do this. You don’t know where you will find money to go to school. It is those kinds of things that make life very difficult.” (Interviewee # 12).

The last extract captures the sense of desperation often experienced by the respondent when there is no money. In this respondents’ case, what discourages her from acting on the desperation is the sense of obligation and responsibility towards her siblings. A further discouragement is that if she were to act on her impulse she might subject her siblings to more illness, suffering and hardship.

The following response follows from the question posed as to *what carrying the responsibility for a household meant to her*:

“It is a very difficult thing because sometimes I don’t have money and there is really no one that can help. I feel like I could just sell my body and yet at the same time I feel like it would be wrong for me to do this because I will get sick and only make matters worse.” (Interviewee # 10).

Despite all the respondents receiving some form of assistance from the organizations responsible for their recruitment, these concerns represent ongoing challenges. These challenges can only fuel the sense of vulnerability and instability experienced by the respondents, often to a point of desperation, as indicated by interviewee # 10.

4.1.9. Grappling with conflicting demands

This particular sub-theme deals with the challenges of running a household as a young person in the context of other competing demands on time, i.e. the pressures of juggling and managing multiple responsibilities. Having to deal with the social pressures confronted by siblings complicates matters even further. These challenges are exacerbated by the fact that the persons concerned are also young people themselves with their own individual concerns and difficulties.

The following extracts depict feelings of being overburdened. These extracts served as responses to the interviewees being asked to describe the challenges they are faced with:

“The challenges that are there...I mean you can’t be a school child, a mother, a brother, and a sister all at the same time. At most times when you come back from school you have your own books and home work to look at. Yet, when your siblings need something, you have to attend to that as well. You can’t say ‘this or that person will handle this’. Everything falls on your shoulders. Those are the challenges I’m faced with.” (Interviewee # 6).

“You know sometimes at my brother’s school there are parents meetings that I have to attend. These meetings clash with other activities, such as school. In the end, it becomes very difficult to do both. I can’t be at school and at the same time be expected to attend parents meetings at my brother’s school.” (Interviewee # 7).

“Sometimes it is very difficult to balance taking care of them (the respondent’s siblings) and attending to my school work. There are a lot of responsibilities...between school and activities

at home, there is just too much. One does not even find time to think because there are just too many responsibilities...in the end one feels pressured to do the right thing. There is pressure to get good marks at school on the one hand. On the other hand, one also needs to be someone that one's siblings could be proud of. There is just too much pressure sometimes.” (Interviewee # 2).

For interviewee # 2, the feeling of being overburdened also betrays a fear of failure both at home as well as at school. This contention is supported by another statement by the respondent made later in the interview. The response was in reference to the interviewee being asked to describe some of her fears and concerns:

“To fail would be my first fear. I have never failed any grade ever since I started school. This year things are very challenging. That is like big. On the family side, I would like to see us remain as we are.”

At home, in particular, the reported fear emanates from a feeling that her family is disintegrating, to be reported later under helplessness and uncertainty. It is also apparent from the two extracts as well as from other responses to be reported on later under helplessness, and uncertainty, that she saw it as her major responsibility to ensure that ‘things’, especially things at home, do not fall apart. The extracts give the impression that these young people take their roles very seriously. They show a great concern for getting things right. Yet, what is clearly evident is the stress and pressures involved in doing everything and also striving to get everything right.

One other difficult issue confronted by child-heads that became evident during the interviews relates to the need that siblings experience to conform or fit in with their peers. This often presented itself in the form of a desire to have the latest fashion outfit, cell phones, etc. What makes this particularly hard is that considering the difficulties at home, fulfilling these desires is almost impossible. In a sense, this issue leads to frustration and even despair, especially for the child-heads, as indicated by the following extracts:

“I would say that some of the challenges, especially when it comes to looking after my sister is growing in this world where everybody is trying to keep with the world...it is very difficult to provide for certain things because nobody at home is employed. Whatever money that we have

is there to cater for the basic needs...at the moment, my sister does not have a cell phone...she complains about this often...that is the one challenge I am confronted with where she is concerned...” (Interviewee # 1)

“My situation becomes more difficult because my younger sibling is very fashion conscious...for her fitting in is very important. Her friends are also just as fashion conscious.”(Interviewee # 5).

4.1.10. Helplessness and uncertainty

The issue of helplessness, vulnerability and uncertainty emerged from the discussions held. This manifested in various ways: preoccupation with personal safety; concerns over family disintegration; instilling discipline; preventing abandonment as well as uncertainties over the future.

Some of the female respondents expressed concerns and fears regarding personal safety. One of the interviewees pointed out during the interview that many young females in similar situations feel that they are vulnerable to sexual assault as they live alone. In this regard, she cited an example of someone that she knows who is also a child-head and has been sexually assaulted by a relative. Other interviewees mentioned living with the uncertainty or fear of being burgled because of the same reason provided above, i.e. living alone.

Although unique to interviewee # 2, another concern and source of helplessness to emerge is family disintegration. This fear is borne from the experience of having one of her siblings disappear constantly. As depicted in the following extract, she feels helpless and unable to do anything to prevent this from happening:

“If only my sister could come back, sit with us and explain why she always wants to run away. What is it that she thinks is going wrong, and what she would suggest we do differently to correct...I feel like my family is falling apart. It is not the same family I knew before my mother died (long silence). Our home was very warm when my mother was still alive. You could feel the love and the warmth but now it just feels empty.”

Various other manifestations of helplessness and vulnerabilities transpired from the interviews. The next extract, taken from interviewee # 3, focuses on her feelings of helplessness when it comes to instilling discipline in the household:

“You cannot take sides because if you do the other child might get angry with you...at times you just have to speak to them, but then this does not always work. It has happened that when trying to discipline one of my younger siblings, the fight just got bigger to a point that everybody got involved...my younger sister is stronger than me when it comes to instilling discipline...when she talks everybody listens. But then when I talk nobody listens. I end up crying as a result.”

The next extract centers on the eighth interviewee’s anxiety over losing her home. It is apparent from her response that she feels this way because there are only children at home and that they are thus helpless and vulnerable to property grabbing. When asked about her fears and concerns, she responded as follows:

“My biggest fear is that somebody may decide to take our house, especially because there is no adult at home...what has brought this fear about is because there is no adult at home. Anybody could just come and lay claim over the house. Anybody could claim to be a relative and produce documents that prove that the house belongs to them, and we would not be able to do anything about it.”

The following extract revealed both a fear of abandonment and a sense of helplessness. The extract was taken from the first interviewee’s response to a similar question as the one posed to interviewee # 8:

“The one fear that I have is that what will happen to us if the help that we receive from Aynage CFDO were to cease. Before we got help from them there was another organization that used to assist us. When it withdrew we were left stranded for two months without food... so the one thing that worries most of us is this” (Interviewee # 1)

It should be mentioned that the above fear and the feeling of helplessness inherent therein were very common among the respondents. This attests to the significant role that the organizations assisting the respondents are playing in their lives. However, in the case of interviewee # 1, the

feeling stemmed from an actual experience with being abandoned by an organization that used to provide assistance to his family.

The next case reveals a different source of helplessness and uncertainty. Before this response, the interviewee mentioned that he tends to think a lot. The excessive thinking seems to indicate a great deal of anxiety over his future. When asked by the interviewer to describe what he thinks about, he responded as follows:

“I am always thinking about my life and the future. I think a lot about my future. What is going to become of me when I finish school? What am I going to end up as in life? I have dreams of becoming a nurse. Will I be to fulfill this dream considering that I have nothing at the moment? Those are the things I think about a lot.” (Interviewee # 9).

The above extract also indicates a need by interviewee # 9 to make succeed in life, so much so that it is something that he is constantly preoccupied by. What came up earlier in the interview with interviewee # 9 is that at the time his mother illness, she asked him to persevere with schooling. It is probably against this background that the need to continue with education becomes very significant. Yet, the fact that he has no foreseeable promise of support with education presents a challenge and a source of helplessness and uncertainty regarding his future.

4.2. Being a Head of Household: Assuming Parental Responsibility

Interviewee 1: “I started taking the responsibility of the household in 2011-when my mother became sick. She became seriously sick and passed away.

In the same year my father became sick and died. That was when I started doing some casual work for a living for myself and my four siblings. Because I am the eldest, I have taken this responsibility to keep my siblings together in our parents’ home.” (15 years girl).

Interviewee 2: “My father was sick for a long time and passed away in 2004. We continued staying with my mother until she died in 2005. I did not know what to do because both our parents who used to look after us died. Only the three of us remained. I am the eldest. When I

saw the situation, I started doing some casual work to earn our living and days were passing like that,” 17 years boy.

Interviewee 3: “We only used to live with my mother until she became sick and died in 2009. I used to work hard in causal work in order to look after my mother. Later she died, as I am the eldest, I had also become responsible for my two younger siblings – my brother and sister. I always try my best to do some causal work,” (18 year girl).

Interviewee 4: “I became head of household in 2008. My father died in late 2007 and so did my mother in the same year. I started being head of household while my mother was sick and continued still, because no relatives wanted to take care of us.” 15years girl

Interviewee 5: “I am 16 years old. I became a head of household in early 2011. My father died in 2011 while my mother died in 2012. It was in that same year when I began to take care of my younger three siblings and myself through doing piecework,” 16 years boy.

Interviewee 6: “I am 18 years old. My mother died in 2002 and my father died in 2004. After losing both our parents, we were taken to our relatives who rejected us saying, ‘your parents were not good’. We began to live along together. That is why I began to do piecework.”

Interviewee 7: “My mother died in 2010 while my father died in 2011. When my mother died, my father remarried another woman. I began to take care of my three young siblings and myself because our stepmother did not want us. 17years boy

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

Interviewee 8: “Relatives nowadays will not look after you unless you have money. They would prefer to look after their own children. They may buy clothes for their children but they would not bother about you.” 15 years girl

Interviewee 9: “You can go and stay with relatives but they differentiate. Let me tell you the experience of my younger sibling who has once been taken by our relatives. He told me that

they bought things and eats without giving my brother even though he has seen them.” 17years boy

Interviewee 10: “I will say this: when we were taken to our relatives they rejected us.” 15 years girl.

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

Firstly, because they were the *eldest child* in the household, most children in the study were assuming parental responsibility and becoming a head of household during the illness of their parents and continued after the death of their parents. As household incomes dwindled with the parents’ illness and death, all of the household heads in this study stopped attending school, for they have been committed to care for siblings in the household. They spent much of their time looking for casual work to provide adequate food for the household and managing the meager food supplies. It seems that being the eldest sibling in the family is a motivational factor for the children in the study to take the headship responsibility.

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

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

4.2.1. *Being a Head of Household: Perception*

Most child household heads managed to find some joy and satisfaction in being a head of household despite the hardship. Replies of some of the participants that may provide evidence for example “ Interviewee 11: Despite the fact that I have discontinued my education, I have become a better person because I now take care of my four siblings. I should not get involved in any bad habits because I will then not set a good example for my siblings that I am looking after. I have learnt a lot about taking care of others.” 17 years girl

Interviewee 12: “We lived in extreme poverty- with a meager income. However, it gives you pleasure when you use the resources well even if it is insufficient.”

Interviewee 13: “Though the living conditions we are living in make me sad, I sometimes become happy being head of a household. Especially, when people around – especially the neighbors- encourage me saying ‘good boy, please keep on your responsibility, everything will pass, be strong ---’, and I become very happy.” 16 years boy

Interviewee 14: “My parental responsibility helps me a lot. For example, I have learnt patience. I have been able to manage myself and my siblings. That is the best of all.” 18 years boy

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

Interviewee 15: “Nothing. I have so many problems taking care of the children that I sometimes think of killing myself.”

“I am not happy either, when I hear some people calling “mother”, I feel very bad. Because I am also still a child”

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

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

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

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

4.2.2. *Being a Head of Household: Leadership Strategy for Survival*

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

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

“I sweep the house, and then my younger sister washes the dishes. The other one is a little boy, he does not do anything.”

“I usually get up early in the morning and do all the housework by myself before I go to work. I do this because I do not want my siblings to get tired from doing household chores so that they can focus on their education.”

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

“I leave for work at 6 o'clock so I do not help with the chores. But the children have divided duties among themselves. They each know what they are supposed to do every day.”

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

“The way I divide the work at home is that I make sure that all the work I have given them to do is done well and nobody is complaining. “No, you have given me difficult work”, and so on. I make sure we work together. I also give myself something to do---- because as the oldest, I am supposed to lead by example, I should not give all the work to the young ones just because I am the one who fends for the home.”

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

“Sometimes it is difficult to control my younger siblings; you try to teach them or advise them, but they continue doing the same things. By then, I sit him/her down and say, “Listen, we have been left alone in the world, just as we are. You should listen when I am teaching you. There is no one who can teach you better than I can.”

“Sometimes my siblings do not listen to what I tell them, especially concerning duties. I call my neighbors to come and help me when I fail to manage them. They talk to them. It does work because my siblings do change after being talked to.”

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

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

Housework has been dealt with in different ways by the child household heads in the study. Many of the boy household heads have never been involved in doing housework and they have

delegated the housework to their siblings. In the girls headed households, responsibilities have been shared in doing the housework. The girls either took all the housework upon themselves or shared it with their siblings. It seems that housekeeping roles in these households reflect the gendered nature of responsibilities in the Ethiopian culture.

4.2.3. *Being a Head of Household: Household Care Giving Challenges*

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

“Since our parents died life has become tough. Sometimes we just eat once in a day, and we do not have clothes. Unlike when my parents were alive, I now have to look for piecework to raise money for looking after my siblings. I sometimes sell items such as cigarettes, soft paper and chewing gum at bus stations. I sometimes wash clothes for other people in the surrounding area. I get paid up to 100 birr per month and it is not enough to buy food for my four siblings and myself.”

“Since our mother died, I have left school to look for jobs because I have no money to pay the fees of my siblings and feeding them is also a big problem. I work now as housemaid. I do all the housework, but the pay is too little.”

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

“We suffer so much since my mother died. I do not manage to provide sufficient food and clothing for my siblings as well as to pay their school fees. Now, I work as a guard for ‘X’ dairy farm. I get 150 birr10 per month, too little to cover the needs of my three younger siblings.”

“At first, I used to buy goat and re-sell it then I went broke. I started selling onion, tomato and potato, but I ran out of money again. Now I just wait for the food support (such as wheat flour and food oil) that has been provided for our household by “X” organization on a monthly basis.”

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

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

“Sometimes a child is sick but you have no medicine to give him/her. This is sad.”

“When your siblings get sick and you do not have anyone to help you, it brings sadness.”

“There is no happiness when your siblings are sick. This sometimes makes me cry, crying deeply. This sometimes makes me feel mad.”

With regard to external help, participants said that they had been supported in the form of food, clothing and educational materials by service providing institutions such as NGOs. However, most participants indicated that the support they had received from such organizations were insufficient in addressing the severity and magnitude of the problems they have encountered in their households. Also, some participants reported that they had received vocational and skills training with the financial support of NGOs. Notwithstanding such efforts by NGOs none of the participants who had received skills training could find employment opportunities.

“With the financial support of “X” organization, I have received the training on ‘Hair Dressing’ for three months. However, I could not find a job since then.”

“Soon after the completion of the three months training on “Tailoring” offered by “Z” organization, I was intensively looking for jobs, but it was in vain.”

“We have been offered a group based training on “Wood Work” for three months by “Y” organization. The group comprised of 20 members-1 and 19 other orphans and school drop outs drawn from different parts of the city. The organization offered the training with the aim to engage us (the group) in income generating business activities. After completion of the training, this organization has also offered us 5,000 birr as a startup capital. However, we did not manage the business properly so that we have been scattered. You see, because on the one hand the raw materials were expensive so that we could not make profit out of our products and on the other hand there was no work discipline among some group members.

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

“For me, I just felt anguished because my mother’s illness was going forward.”

“During my mother’s long illness, I used to sit alone at home, think and worry for long.”

“I used to feel very sad during my mother’s illness because she used to worry and complain so much. She used to say, ‘who will look after my children?’ and sometimes she would cry. I would also start crying. The day she was taken to the hospital she told us not to worry. I was crying deeply. She stayed in the hospital for a few days then she died.”

“What hurt me most was finding my father lying in bed after coming back from school while my friend’s fathers would be moving here and there looking healthy.”

“When my parents were sick, I felt grief. When they were taken to be buried, relatives took me away. I wanted to visit them while they were in the hospital, but----,” (Broke off in tears so that I stopped probing).

“I remember how they used to take care of me. I always felt sad when I looked at their pictures. Look at the picture. I wish they had not died. If they---“(Broke off in tears so that I stopped probing).

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

Many problems the children related centered on household economic security issues. All the study participants related stories of serious economic insecurity. The results are consistently similar with all study participants experiencing severe difficulties acquiring sufficient food, providing access to education and health care and often time having problems of providing shelter.

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

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

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

been given has saturated the market or the skills training has been provided with little consideration for the children's preferences, interests and choices. The outcome of this situation may provide insight to the service providers, especially NGOs, pertaining to skill training in their planning and intervention mechanisms.

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

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

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

4.2.4. Being a Head of Household: Strategies for Coping

Resilient children are able to manipulate and shape their environment, to deal with its pressure successfully, and to comply with its demands. They are able to adapt quickly to new situations, perceive clearly what is occurring, communicate freely, act flexibly, and view themselves in a

positive way. Compared with vulnerable children, they are able to tolerate frustration, handle anxiety, and ask for help when they need it. (James Garbarino 1992:103)

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

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

4.2.4.1. Social support

Experiences of social support cited can be classified under spiritual, instrumental and moral support. Spiritual support reflects experiences with support from church/mosque members. This was mainly expressed through church/mosque members praying for particular interviewees. What is also apparent from the responses is the significance and importance that this holds for the particular interviewees. When the interviewer asked interviewee # 11 where she gets her strength from, she responded as follows:

“I go to church. I talk to people in church about how things are at home. They always make it a point that they come over to visit and pray for us. Everything after that always feels better...”

The next section explores the issue of religiosity and faith as a coping mechanism in greater detail.

Instrumental support included instances where some respondents reported having received tangible support from neighbors, relatives or even a school principal. After interviewee # 13 pointed out that the teachers at his school are aware of his situation at home, the interviewer asked whether he felt that the people at school were sympathetic. He responded thus:

“I would say that they are sympathetic because the school principal has told me that I should not be paying school fees. This has certainly lessened my concerns.”

Another example of instrumental support comes from interviewee # 1. The interviewee's response was in reference to the interviewer's question on how he would describe his and his siblings' relationship with their relatives:

“When my parents passed away we became even closer...there is no one in the family that is well off. There is no one in the family that is wealthy or very successful financially. Yet, in spite of that our relatives always make it a point that they share whatever they have with us. Whatever they have they share with us.”

The above extract points to the poverty that not only affects the respondent and his siblings, but also extends to other family members. By drawing attention to this, the interviewee emphasizes not only to the nature of the relationship. It would appear as if he is conveying a sense of gratitude.

In other examples, respondents reported instances where in the absence of tangible help, those around them have offered a word of advice, encouragement and motivation. These responses were classified under moral support. The next two extracts are illustrative:

“Community members are very supportive you know. They always ask how I am or where I have been if they have not seen me for a while. Although I sometimes think that they are fussing over me but I have grown to understand that they are just concerned about us.” (Interviewee # 5).

“Certain community members know about our situation at home and they are very sympathetic. They always share a word of encouragement and sometimes help where they can.”(Interviewee # 11).

Although a number of respondents could cite examples that could be classified under these three levels of support, some were quite skeptical regarding the interest and support shown.

4.2.4.2. Religiosity

The issue of religiosity reports on references to faith and religion as a coping strategy and as a point of reference for making sense of difficulties.

Interviewee # 9 stated that “whenever I start feeling bad about things that happen I kneel down and pray. Through God I managed to overcome many struggles in my life...despite the difficulties, life still goes on. I think God really does feel for me. I really do thank God.” In the

preceding response the relationship with God also serves to inspire hope and belief in triumph in the face of ongoing adversities. When the interviewer remarked to interviewee # 11 that it appears as if the support that she receives from her fellow church members is very important to the respondent, she responded, emphatically:

“Yes! When you don’t have this relationship or when you don’t read the bible things don’t always work out. It is very important.”

From the above extract, it would appear as if the respondents’ ability to cope is seen as dependent on her reading the bible. She believes that by reading the Bible, matters have the potential to work out for the better.

The next sub-theme presents findings on positive outlook and attitude as expressed in the interviews.

“I pray when I start feeling bad, I feel much better and calmer after pray.”

“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.”

“I always go to the church and pray. I take all my problems to God. No grief and no pain at all.”

“People from the Mosque used to come and read the Quran with me. They used to tell me that death is inevitable and that all of us will die. They used to encourage me and I would feel a lot better after talking to them. I know we (I and my parents) will meet in heaven.”

4.2.4.3. Positive outlook and attitude

This issue focuses on particular instances where a positive outlook and attitude was apparent.

However, this involves more than just an attitude. This section includes instances where these respondents displayed a positive view of themselves and a determination to survive against all odds. This is apparent from the sort of career options that respondents mentioned pursuing.

Examples varied. Interviewee # 1, for example, sees himself becoming the next Sheh Mohammed Al-Alamudin in the sense of developing his own business. Interviewee # 2 imagines obtaining a professional qualification in one of the Ethiopian Universities. This attests to the positive role that the organizations assisting the respondents are playing in cultivating self-belief. All of this becomes even more important considering the circumstances that these respondents have to live with. Interviewee # 1 exhibits a very profound and mature view:

“The one thing I know is that the moment you put a little bit of negativity, everything turns negative. You have to be positive every step of the way. You just have to be positive. When you have a positive attitude things begin to happen. If I was not positive, I would not have met people like Aynage community facilitators, from the organization assisting us with school materials, and whatever financial problems that we have you see.”

In the above extract, interviewee # 1 recognizes that having a positive attitude has helped bring in support for his family. Implied in his response is that a negative attitude might not have attracted support and compassion from other people. The spirit of determination from the same respondent was also apparent when he was asked what being a head at home means to him: “it is about waking up each day with an inner resolve to make something of the day”.

Later on, he described to the interviewer what he regularly to motivate himself by saying: “I am going to make something new. I will not fail”.

The next example comes from twelve interviewee’s response to a follow up question on how she feels about not being able to participate in activities that young people her age are involved in. Instead of viewing this negatively, she provides a very positive account of how she sees it:

“I feel very proud of myself because other children my age lack self control even though they have parents to guide them. Some of them are involved in very destructive activities. I feel very proud myself because despite not having parents I have self control and I can look after myself.”

Interviewee # 12 seems to have an intuitive realization that her character or the sort of person that she saves her from trouble. Her response also betrays self-appreciation and pride as well as

a positive self-esteem. It also reveals a steadfast determination to remain her own person when some other young people conform and capitulate in the face of negative peer pressure.

4.2.4.4. Sharing Grief with other similar peers

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.

“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.”

“I used to feel better when my friends – who are orphans- took me to play with them. When I came back, the grief was there until I prayed.”

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

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

4.2.4.5. Deriving meaning out of hardship

In these sub-theme responses reflecting how some respondents derive positive and constructive meaning from their present circumstances are considered. This sub-theme encapsulates interviewee one’s view that: “I feel like, for me, it is like a learning curve. I am learning to be responsible at such a young age”. He continues: “when I encounter difficulties when I am older I will have experience dealing with them”.

The experience of heading a household holds a similar meaning for interviewee # 12: “I think it shows that when I am older I won’t have difficulties running my own home. I won’t have difficulties looking after my own children”.

It is apparent from both respondents that they see a foundation for the future in the current situation.

The respondents view this groundwork as something that will make them stronger individuals who will have experience in handling responsibilities. Also implied is the feeling of mastery over what may be considered adult responsibilities, something that makes them unique and separates them from their peers who are not in the same situation. Contrary to the focus on the future as is the case with the previous respondents, the next respondent finds meaning in the present:

“I find inspiration from our present circumstances...the life we live inspire and motivate me. It teaches me to do things properly...for instance I must avoid rushing things. I should not get pregnant because doing so now will only worsen the situation at home...it helps discipline me. Even when I think of skipping a class at school I should always remember what life is like at home.” (Interviewee # 7).

For interviewee # 7, the experience of heading a household has currency in the present. In her case, it helps instill discipline and reduces the inclination to be impulsive. Constant recognition and consciousness of her situation also serves to protect her from making the sort of decisions that are likely to have negative consequences not only for her alone but for her siblings as well. It helps her avoid getting into situations that can only exacerbate the situation at home.

4.2.4.6. Restored sense of purpose and meaning in life

An overwhelming number of respondents described how, through the association that they have developed with the organizations assisting them with their basic needs and other organizations in civil society, they have had their purpose and confidence in life restored.

This association also includes certain people in their communities. The feeling of confidence is borne from the fact these respondents have seen improvements ever since their relationship with these organizations started. Attesting to this are the following responses by interviewees # 1 and # 9. Interviewee # 1 was responding to the question on what he thinks has changed from the time immediately after his mother's death to the present.

“When we started receiving help from Aynage CFDO and other organizations...with the help we received I was able to go back to school. They even helped us with the funeral...I would say that they actually gave me back my life. I had given up on life...” (Interviewee # 1)

Interviewee # 9 responded as follows to question on what has changed from the time immediately after his parent's death:

“Ever since Aynage CFDO came into the picture, they have provided useful guidance...presently, in my view, I think things have improved a lot because of Aynage CFDO. The organization is like a mother or a father...if it were not for them I would have left school. The organization has given me the courage and guidance I need to succeed.” (Interviewee # 9).

A number of other similar descriptions from other interviewees alluded to the same point, especially regarding the difference that these organizations have made. Some respondents also felt that a number of individuals within the community had played similar supportive roles. In this particular case, the interviewee was describing what her friends mean to her:

“They have stayed the same throughout. In fact, they have not changed at all. They are still the same friends and the best people one can have...in 2011 when my mother died I almost broke, but they were there for me. They actually said to me ‘you can do this’ and all that. My friends picked me up at a very difficult period in my life.”

Three issues emerge from the above extract. The first is that the respondents' friends have remained the same throughout her tribulations. Secondly, her friends were there for her during a very difficult period in her life when she lost her mother. Lastly, her friends encouraged and motivated her when she was inclined to give up.

4.3. *Being a Head of Household: Views on the Future*

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

“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.”

“I do not have anyone to advise me or who can assist me keeping the young siblings or me. I have remained with my siblings. We will continue keeping ourselves, God is with us.”

“As for me, I do not expect to be kept by relatives in the future; we are alone, because they failed to keep us soon after the death of my parents. Now that I am so much older I can take care of my siblings.”

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

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

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

4.3.1. Perceptions of Siblings in Child Household Heads

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

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

4.3.2. *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. Participants reported that they have often been supported with food and other educational materials such as exercise books by neighbors and friends. This indicates the community response to the needs of orphan children is not only promising but also reflects a level of acceptance of these children after the death of their parents.

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

“Three months after the death of our mother, my aunt came and took me to her home. My aunt is rich. She has a restaurant. She promised education and other support when she took me to her home. However, I found myself as a housemaid in her house I did all the housework. I baked Injera. I washed clothes etc. Her husband always----- then----- . If my mother were alive-----”(kept silent for long and discontinued her reflection).

This contracting 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.

4.3.3. *Perceptions of Siblings towards Their Deceased Parents*

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

“Things changed from the time our parents died. They used to give us support. We used to enjoy playing with our friends; I was a happy person. When I went home from school, I would find my lunch ready. Now, from the time my parents passed away, things changed. We sometimes eat once a day now--.”

“When your parents are alive, you will get the love and material support that you need, and whatever you ask for. Losing one’s parents has brought so much misery-----so much----so.”(Broke off into tears).

“I do not feel nice (about the death of my parents) because you find that your friends (who have) both parents ----- when it is their birthday, their parents buy them presents. Now with me, my parents are not there to buy me any presents.”

“Our parents used to buy gifts during holidays-----my mother used to call me ‘my honey, my princess-----.’ (Stopped talking and kept silent for long).

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

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

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

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

4.3.4.1. Reverence:

“Before the death of our mother we (she and her elder sister) used to fight both verbally and physically. Now I do respect all her words. You see, she dropped out of school and does all the work she can get for our survival. ”

4.3.4.2. Shared responsibility:

“When he goes to work, we (he and his sisters) do all the housework. We also wash his clothes. He usually comes home tired, but when he sees our home clean he becomes very happy. When we see his happiness we also become very happy. ”

4.3.4.3. Empathy:

“Before the death of our parents, my brother used to be good at his education. He dropped out of school since the death of my mother and do casual work now so that we (I and two of my sisters) are able to continue with our education. I always sympathize deeply with his soft-heartedness to support us since the death of our parents. I promised myself to be successful in my education and to change his life. I am very good at my education. I always score high marks.”

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

4.4. *Day to Day Challenges: Problems versus Perceived Needs*

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

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

“I know a family which was affected by HIV/AIDS. During the illness of the parents the family income worsened. Even before the illness they were living in a very bad economic situation. The parents died within a year of each other. After the death of their parents, the two children faced serious problems. These girls were our age. As they did not get any close relatives to support them, they were forced to have friendship with those girls working in the street and bars. Gradually they became engaged in prostitution at an early age which caused them to suffer the same fate as their parents.”

“I know a nine year old boy living with his mother. His mother, after suffering from illness for a long time, died in her house. The cause of her death is said to be AIDS. The boy lacks anyone to support him for his house rent which forced him to leave the place and live with street children in Worabe the capital town of the zone. I have seen him one day wearing a very dirty cloth.”

“We know some orphan girls of age 13-17 who were forced to have sex relations with adults to get money. Even if you go around the asphalt road you can watch teen-age girls wondering here and there specially in alcohol drinking places to find drunkards.”

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

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. Some of the responses are as follows:

“I want to be a doctor, because my mother used to tell me that ‘I am a good girl to become a doctor and help sick people’....”

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

In general, running away from home was not a salient issue for all the research participants – both the child household heads and their siblings – despite living in abject poverty. There has been a strong commitment of many of the child household heads to look after their siblings both now and in the future. The stories of the siblings have also reflected the same that they have been committed to bring changes for a better life. On top of this, siblings did respect the words of their existing care takers – child household heads. For example, though sibling rivalry was common when their parents were alive their relationships are more often 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 involve in anti-social behavior.

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

4.5.1. Trepidation over social interest and support

Interviewees # 1 and # 15 conveyed a sense of trepidation regarding the interest, and to a certain degree, the support received from some community members. There were, however, differences in how this issue was expressed. Interviewee # 1 was very interested in the interviewer's occupation at the beginning of the interview. In fact, he wanted to know whether the researcher is from the media. This comment made sense later on during the interview when the respondent made the following reference to heartless and insensitive people:

“There are people in the past that have made promises. Certain people have made promises, empty promises, which at the end of the day add up to nothing....others, especially the media, when they want a headline story, they make certain promises. They promise to help you with this or that thing. These become just empty promises at the end of the day...it feels like we are a laughing stalk really...”

In a similar tone, the respondent also showed skepticism later during the interview over support shown by certain community members. He felt as though some community members were not genuine with their support and only provided help so that “the whole township knows about it”:

“Other community members let me say that you urgently need money...they always take time to help you...you have an urgent need for it and yet they always take their time. They do have the money. They just want to give you the run around. This feels like they are making fun of you

and they just want to feel important at your expense...when they do something for you, the whole township has to know about it.”

In both extracts, the interviewee shows a deep level of skepticism and cynicism. It appears as if he feels that those around him take his situation for granted. He seems to feel that other people are using his situation only for their own gain and glory without due regard for him or other young people in his situation. Whether justified or not, it is apparent from the extracts that interviewee # 1 felt very aggrieved when it comes to this issue. Another example pointed out during his interview related to do with instances at school where teachers use young people in his situation as examples during class discussions on poverty:

“At school when there is a discussion about poverty and suffering – you provide the perfect example. Whatever you say will be considered as authoritative or wise because you have been or are going through that situation. When another person who is not in the same situation makes a contribution to the discussion it will not be considered...this is not nice because you are actually being judged at that point...”

Although the teachers may mean well in inviting his input in the discussion, such behaviour causes damage to interviewee # 1.

Interviewee # 15 felt that moral support alone was not sufficient. In his view, moral support would be more meaningful if backed up with actual tangible support:

“Most people in the community just talk to us only – they do not give us anything. They just tell us to get educated. It’s just that and it does not help us very much...it should not be words only and no action. People should back up their words with action.”

Interviewee # 15 may perhaps be overlooking the possibility that other people in his community, which happens to be in a rural setting, are also caught up in their own poverty.

Thus, although they may want to help, they may often be unable to. As a result, the only form of support that they could provide is moral support. However, this assertion was not validated or reflected back to the respondent during the interview.

4.5.2. Social criticism and judgment

This issue deals with experiences of criticism, stigmatization and judgment from other community members. The section also considers the responses reflecting fear or avoidance of criticism and rejection. It should be mentioned from the onset that, while these experiences emerged during the discussions held, the interviewer was unable to establish whether these feelings were related to how the respondents' parents had died.

The most lucid responses on experiences of criticism and judgment probably stem from the next few extracts. The first quotation is taken from interviewee three's response as to how she would describe her relationship with her neighbors. She commented on how some people are quick to judge her without a sufficient understanding of what it means to be in her situation or which factors within her home leads to her behavior outside the home. The behaviour in question is what, in her opinion, some community members view as her 'arrogant' attitude. Although she initially stated that her relationship with her community "is quite good", she revealed the following later on in the interview:

"Actually people can like reject you and stuff. They think that, okay the mother is not there or whoever is not there (inaudible)...they tell you about the things that you do outside but then they have no clue what happens once you go in that door. They are like outside you do this or that without any understanding what happens in the house that leads to what you may be doing outside."

4.6. Community intervention

One of the questions asked during the interviews, although not consistently, related to how the how the respondents could be assisted. The question focuses on the role of the community or civil societies in assisting young people who find themselves in this situation.

Before discussing the findings that emerged, it is important to note that a sense of responsibility towards the community transpired from the texts. Despite the concerns expressed regarding their own survival, it was also apparent that the respondents recognized, at least to a certain extent, the suffering around them. Interviewee # 1 mentioned that she would like to

help out in the community. When asked exactly how she sees herself assisting the community, she responded as follows:

“Just give back to the community what they gave to me. I just want to help out in the community because when you look around there is a lot of poverty and suffering in the community. There is a lot of suffering in the country. I just want to help out and make a difference someday”

Responses from other participants had a similar tone. Examples are apparent in instances where respondents were asked what they would like to do when they finished school. Some mentioned professions centred on helping others as possible future career options, with social work being the most popular idea. When asked to elaborate further, these respondents identified difficulties faced by other people around them that they would like to make a difference in. Perhaps out of their personal experiences with suffering and poverty, there is a growing sensitivity and empathy for the suffering of those around them.

Some interesting ideas emerged from the texts on how young people faced with adversities could be assisted. The following response focuses on action that will result in material improvement. Central to this proposal is the need for the community to become proactive and achieving community solidarity in the interest of vulnerable children in the communities:

“What I would like to see, what I hope will be done in the future is for the community to actually join hands and just not sit back, but spring to action...I believe that there is a lot that can be done if the community sat down and planned or if the community would donate towards some fund geared for buying clothes for disadvantaged children. The same fund could also be utilized for groceries and other things, such as school fees.” (Interviewee # 12).

The next respondents focused on more attention, interest and having people from the community that they can talk to. Interviewee # 2, in particular, points specifically to the need for a mentor as well counseling and guidance for children carrying the burden of responsibility for households. Also important, as implied from interviewee 2's response, is the idea that community members should be doing more by simply being there. The central ideas emerging from the following extracts are one of a need for community acceptance and belonging:

“For me, I would say that they should give us positive feedback and things like that...they should also just talk to us. Talking does help...”(Interviewee # 3).

“To have somebody that one talk to is very important. Sometimes a person can be given things, but a person also has to be listened to...I think that people should take it upon themselves, I am not saying that they should replace our parents, but they could be mentors.

Sometimes it is not easy to talk to one’s friends at school or anywhere else for that matter on personal issues. We need people that can play that role of a mother or father, although I don’t mean that they should replace them...we also need counseling because sometimes someone may do something stupid because they assume that it will ease the pain...so without people do educate us nothing will ever be right.”(Interviewee # 2).

The previous sections reported on the interviewee’s experiences with illness and death, both parental or sibling, post-bereavement adjustment challenges and psychosocial effects. The section also discussed the interviewees’ experiences in the community/society along with their views on how the community could be assistance to them. The last section will focus on how the interviewees deal with the situation that they find themselves in.

Summary of the Main Themes

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

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

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

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

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

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

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

children. The child household heads in this study face the burden of caring for siblings with no adult help. All of these households live in abject poverty and have little capacity to manage. Many rely on erratic casual work and the kindness of neighbors.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1. BRIEF SUMMARY OF THE STUDY

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

The study employed an exploratory research approach with a purposive sampling technique that aimed to ascertain how child household heads affected by AIDS adapted to their changed circumstances, what events meant to them, how they viewed what had happened to them and around them. The study built upon fieldwork over a period of five weeks in Siliti Woreda. The study gathered evidence from 15 selected households headed by children between the ages of 12-18, their siblings and key informants using in-depth interviews, focus group unstructured interviews respectively.

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

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

5.2. CONCLUSIONS

The findings presented in this chapter demonstrate the type of challenges and psychosocial needs that the children 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. Clearly, having to carry the burden of responsibility for a household as a young person is difficult. These children face a number of challenges at a social, economic, and emotional level. The findings also indicate the difference that social and material assistance (e.g. the provision of food, assistance with school materials, etc) can make to psychosocial adjustment and adaptation. In particular, the findings reveal the inherent resilience of children in the face of seemingly insurmountable challenges.

“Man’s search for meaning is the primary motivation in his life and not a secondary rationalization of instinctual drives. This meaning is unique and specific in that it must and can be fulfilled by him alone; only then does it achieve a significance which will satisfy his own will to meaning.” (Frankl, 1984, p.121)

Carrying the responsibility for a household as a young person, and especially if this responsibility stems from HIV/AIDS-related parental bereavement, is a life changing experience. It is an unprecedented phenomenon, the long-term psychological repercussions of which are at present not fully understood. The findings from this study clearly illustrated that the responsibilities involved are immensely challenging for the children concerned. However, their ability to cope and remain resilient, mediated by social and intrinsic factors, in the face of tremendous suffering cannot be underestimated.

Living with the effects of illness and coping with bereavement

Focusing on the personal experiences of children carrying the responsibility for a household due to HIV/AIDS-related parental death, the study explored the ways in which experiences with illness and bereavement affect adjustment and outcomes. It is apparent that experiences with illness and bereavement present a number of profound challenges and impacts. During the time of parental illness, changes occur. The study revealed that the most significant of these changes is the reversal of parental and child roles. Consistent with findings from other studies, this manifests through increased household responsibilities, the most difficult of which

includes caring for an ailing parent and other, in most cases, younger, siblings (Stein et al., 1999; Foster & Williamson, 2000). Specific experiences with the effects of parental illness that emerged from this study include feelings of loneliness, anxiety as well as negative ramifications for school performance and attendance. Foster and Williamson (2000) point out that the increasing demands made on the young person concerned is likely to affect school attendance and performance negatively.

One example in this study revealed that experiences of loneliness were exacerbated by feelings of shame and the need to keep the illness a secret. A similar finding emerged from a study conducted among a group of children in Scotland who looked after parents with HIV/AIDS. The study revealed that some of these children lacked support and felt isolated partly because they did not want their teachers to know about their parents HIV sero-positive status (Cree et al., 2006).

The public images and views of HIV/AIDS can give rise to hopelessness and despair as well as fears of being stigmatized, as illustrated in the case of one of the respondents. One of the interviewees in the study did not want her teachers and others around her finding out about her mother's condition. This, in turn, resulted in her isolation and alienation.

This result reveals that reducing stigma and discrimination directed at people infected and affected by HIV/AIDS may go a long way in alleviating or improving the plight of those affected. By lessening the negative connotations with HIV/AIDS, people would be more inclined to open up to others and receive help.

Denial and fear of the impending reality emerged from the discussions. In particular, this was found to reflect anxieties around the meaning of the reality itself (i.e. fear and denial of imminent loss, as well as the implications of the loss). As demonstrated in other studies, the fears revolve around what will happen and the looming future reality post-bereavement (Sengendo & Nambi, 1997; and Malinga, 2002). According to Bawa-Yamba (2005) the concern over the future becomes more vexing for children that do not have a surviving parent or when it seems unlikely that someone else will take over the responsibilities. What confirmed the latter in the case of one example from the study was the absence of support, even during the

respondent's mother's illness. It was on the basis of this observation that she felt uneasy about the future, especially at the time of her mother's passing.

Various reactions characterized responses to actual bereavement in the study. These ranged from a deep sense of loss and devastation to emotional repression. Responses were largely based on respondents' recollections of how they responded to loss. Signs of grief were, however, still apparent as illustrated by some respondent's crying.

One of the difficulties experienced by children affected by HIV/AIDS is being subjected to further AIDS-related losses (Bawa-Yamba, 2005). This was the case with two respondents in this study, both of whom lost younger siblings. Interestingly, their reactions to these losses were markedly different. One respondent reported to have been more accepting, while the other experienced it as a devastating blow. The mediating influence of social support is what seems to account for the difference.

For some of the respondents, access to social support proved helpful during this period in their life. One example of a source of social support cited in the present study included friends. Gray (1989) found that for bereaved adolescents the support from peers was considered more helpful than assistance from teachers or even other family members.

Considering that some respondents in this study experienced difficulties in coping with bereavement, it would be greatly beneficial to learn from the experiences of those who were able to find some resolution to their grief. It is suggested that the specific things regarding the available support that assisted participants in coping be recognized in an attempt to create pathways to coping through interventions that develop those conditions conducive to coping.

A number of respondents also reported that they were responsible for providing emotional support to their siblings while dealing with their own grief and sense of loss. Another study (see Naicker & Tshenase, 2004) confirmed that child-heads carry the burden of providing physical and emotional support to younger siblings.

Post-bereavement adjustment challenges and psychosocial consequences

This study also suggests that the period following parental death is characterized by a number of adjustment challenges. These reflect ongoing experiences of respondents with the burden of

carrying responsibility for a household. The severity of the difficulties, as well as personal meanings attributed to these experiences; depend on various factors both internal and external to the person. Internal factors include individual coping styles and personal ways of attributing sense to these difficulties, while external factors include support available to the respondent.

One of the most formidable challenges to emerge from the text is experiences around the loss of childhood and self. Ebersohn and Eloff (2002) identify loss of identity, which includes, amongst others, the loss of self, as one of the psychosocial challenges faced by children affected by HIV/AIDS. In this study, this took the form of respondents viewing the experience as an acceleration of development. Considering that most respondents are adolescence, this process results in a feeling of being robbed from experiencing developmentally appropriate activities.

The responses were also characterized by a feeling that there is less focus and development of the self. According to Erikson (1968), adolescence is characterized by movement towards the formation of a separate identity and autonomy. To emerge from this would be the development of independent thought and an individual's own moral code of judgment.

However, one of the significant weaknesses of Erikson's theory as identified by Stevens and Lockhart (2003) is its inapplicability to contexts beyond the one in which it was developed. Erikson's postulation presupposes that the parents are present and that the adolescent learns to be self reliant by gradually becoming independent from the parents. Central to this process is the style of parenting and the formulation or establishment of extra familial relations and attachments. The theory also presupposes involvement in developmentally appropriate activities.

The central question thus remains: What happens in the case of young people such the ones in this study? Would an identity crisis result from a situation in which the respondents who experienced this loss of childhood felt that their own views of self had become subsumed into the roles they are now expected to play (i.e. mother, father and mentor to the other siblings)?

Because this phenomenon of child-heads can be seen as relatively new, it is very difficult to predict what the long term effects are likely to be. The study revealed, however, that some of the respondents have pieced together ways of engaging with the reality and thus prove to be very adaptive. The process of adaptation itself is a meaning forming process. Furthermore, it would seem that access or lack thereof to social support may prove decisive for long-term psychological health (Rutter, 1981).

Also apparent from the discussions is the sense of ‘obligation to family’ as a driving force. In this regard, the responses centred on the respondents feeling obligated to look after or assume the responsibility of caring for their siblings as well as running the household. The feeling was partly spurred by the absence of somebody else that could fulfill this role. According to Foster (2000), the presence and availability of older siblings who are willing to take care of younger siblings is one of many other reasons why child-headed households appear to be on the increase. This factor was apparent from the texts. It was, however, evident from some of the respondents in this study that this was more than just a question of willingness. The most significant factor was the reported sense of obligation and a feeling of being duty bound. Tied to the aforesaid was resignation or fatalism to the fact of the reality.

One of the other factors identified by Foster (2000) as leading to the proliferation of child-headed households is poverty stricken relatives. Although none of the respondents identified this issue, it might still be a factor. Whatever the reasons behind relatives not being involved in some of the cases in this study, some respondents experienced this as a source of great distress and disappointment. Respondents experienced this uninvolved as being failed by the adults in their lives when they should have been protecting and caring for them.

Children orphaned by HIV/AIDS face a number of physical hardships, including lack of access to food, clothing and social security (Nyambedha et al., 2003; Naicker & Tshenase, 2004; UNICEF, 2004). In this study, this challenge was apparent in the expressions of concerns and anxieties over survival matters. Examples include citation of financial challenges, running out of food in the middle of the month and concerns about having money for school matters, for example, school uniform, and money for tuition. It was apparent from the findings that these

concerns represent ongoing challenges despite the fact that almost all the respondents received some form of help from the organizations responsible for their recruitment. A cause of concern was the indication of desperation by the respondents, e.g. “I feel like I could just sell my body”. As found in other studies (see Ayieko, 1997; Sengendo & Nambi, 1997; Nelson Mandela Children’s Fund, 2001; Naicker & Tshenase, 2004) children in child-headed households are vulnerable to sexual abuse, exploitation and child prostitution.

Child-heads face tremendous stresses (Nelson Mandela Children’s Fund, 2001; Naicker & Tshenase, 2004). A lot of this stress emanates from the pressures of juggling multiple responsibilities. The study revealed that these responsibilities include the pressures of running the household and caring for siblings as well as school work and maintaining part time work.

For some respondents, this resulted in feelings of being over-burdened and led to fears of failure both at home and at school as well as losing control in areas such as discipline in the household.

As far as the respondents in the study is concerned, this phenomenon might be an attempt to avoid the painful feelings associated with parental death, an indication of readiness as well as a process of assimilating the role of parent into their identity and self definition. The findings also revealed the stresses of dealing with the social pressures confronted by siblings. Naicker and Tshenase (2004) found that child-heads experience challenges in maintaining discipline and order. This study revealed that instilling discipline is one of the areas that lead to feelings of helplessness. According to Nagler, Adnopolz and Forsyth (1995), life for children in AIDS-affected families is characterized by a high degree of uncertainty, especially over future prospects following illness and bereavement. The study also revealed feelings of uncertainty over personal future prospects and vulnerability to property grabbing. One respondent expressed feelings of vulnerability and uncertainty over family disintegration. It would seem that these anxieties clearly emphasize the sense of despair and lack of control over the future. For the respondents concerned, these anxieties in addition to experiencing multiple losses may make life seem very unstable and unpredictable.

Another abiding concern and a significant factor in uncertainties over the future was the question of termination of assistance from the organizations that have come to represent an important role player in the lives of some of the respondents. The study reveals that these organizations have assumed a very important and meaningful role in the lives of some respondents. They represent a source of meaning and hope in the future, where prospects at an earlier stage seemed bleak. For some of the respondents, these organizations played a pivotal role when it comes to accepting and living with the reality of their situation.

The mediating and aggravating role of the community/society

The study explored the respondents' experiences in their community. Previous studies revealed that child-headed households are alienated from their communities and extended families, often surviving with very little access to social networks that could provide relief and social support (Bawa-Yawa, 2005; Roalkvam, 2005). It is evident from this study the above is not always the case. The picture that emerges is not one of isolation or lack of access to social support. Most of the respondents in this study had access to some form of social support, for instance the support received from the NGOs that recruited them.

Three forms of social support were identified from the texts: spiritual; instrumental; and moral. With reference to spiritual support, one respondent clearly illustrated that the support from her church played a significant role in her reorientation with regards to making sense and deriving meaning from her situation. It is also apparent that she was able to find some solace from the spiritual support.

The texts also revealed indications that some respondents had reservations about the interest and support shown by community members. In one case, the respondent concerned felt that the support being shown by some members of the community was very superficial. The same respondent pointed out that young people in his situation are often being used to further other people's agenda without due regard for their feelings and how they are left traumatized by these people's unfulfilled promises.

Consistent with the findings by Strode (2003) from the study on challenges faced by child-headed households, some respondents in this study reported on their experiences with stigmatization and discrimination. A number of respondents reported that they felt judged by other community members without a proper understanding of what it was like to be in their situation. One of the interviewees felt that the source of the negative things that people say about her is jealousy over the attention that she was receiving from NGOs and individuals assisting orphans and vulnerable children.

One of the respondents indicated that many children in her situation experiences fear as to what would happen if others find out what the cause of their parents' death was. Lee et al. (2002) found that knowledge of a parent's HIV status can generate fear and uncertainty for the child involved. They also found that maternal disclosure is significantly correlated to a daughter's emotional distress. It may be possible that the same fear, distress and uncertainty continue even after the death of parent, especially since many communities in Ethiopia still view HIV/AIDS negatively. The concern reported by the respondent referred to above might be revealing the need for 'unconditional' acceptance from the community in light of the cause of her mother's death. Her fear is also reflective of her internalization of the stigma and discrimination surrounding HIV/AIDS.

Coping and resilience in midst of adversity

A striking feature about the respondents in this study is that despite the challenges that they faced, the level of resilience and coping reported was higher than expected. This is due to both personal coping mechanisms and available social support structures and systems.

Personal dispositional characteristics, e.g. temperament, high self-esteem, internal locus of control, etc., have been found to improve the prospects of adjustment for children and adolescents faced with adverse living conditions (Garmezy, 1991). Other studies also found that social support enhance coping for children affected by HIV/AIDS (Cree et al., 2006).

For some respondents in this study, personal ways of making sense of the reality that they are faced with was characterized by a sense of resignation. For these respondents, the situation that

they find themselves in becomes the organizing principle in their lives around which they formulate meaning. Closely tied to this is the belief in a predestined and fated existence. It is a way of engaging with what has happened to them in an accepting and non-accusatory way.

Religion is often but not always associated with the above. For one respondent in particular, adherence to religious practices represented a way in which she could improve the prospects of adjustment and adaptation. This was accompanied by spiritual support from fellow church/mosque members. Other studies found that support from church/mosque leaders and members improved the psychosocial prospects for children and young people made orphaned and vulnerable by HIV/AIDS (Wild, 2001).

A 'never say die' attitude emerged as another coping mechanism for some respondents in this study. Two of its features are self-belief as well as a positive outlook and attitude. As noted previously, a high self-esteem improves adjustment for children and adolescents confronted by difficult living conditions (Garmezy, 1991). Central to this is positive self talk.

Viewing their burden of responsibility in ways that could derive meaning from hardship also emerged as a way in which respondents make sense of their situation. Respondents have discovered ways of viewing their situation as preparation for adult responsibilities and roles in the future. They see themselves as developing skills that will help them develop an edge over their peers.

There are many perceptions and ways of understanding the predicament of being a child-head and individuals are attuned to specific perceptions more than others. As opposed to deriving meaning for the future in the present one respondent saw relevance in the present.

For some respondents, the role played by the NGOs that recruited them is crucial to the restoration of a sense of purpose and meaning in life. . The impression created by these respondents was that the organizations provided redemption or a second chance in life.

5.3. RECOMMENDATIONS

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

Positive network support can go a long way to change the emotional, psychological, social and spiritual breakdown of the lives of HIV/AIDS orphans who find themselves with the responsibilities of heads of households and children orphaned by other circumstances. This study proposes a joint approach of government, churches, mosques, communities and NGO's to address the appalling situation of the growing number of orphans and child headed households in Ethiopia with particular emphasis to the study area.

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

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

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

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

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

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ANNEX 1.

INTERVIEW GUIDE:

I. INTERVIEW GUIDE FOR LIFE STORY COLLECTION

INTRODUCTION

Good morning/good afternoon. My name is Nigus Tadesse. I am Master of Arts student at Indira Gandhi Open University School of Social Work. The objective of this study is to explore the situation of child headed households affected by HIV/AIDS in Silti Woreda. As part of my study, I am going to discuss the situation with you. I will use the information I obtain from you to provide a clear picture of the roles and challenges of household care giving in child headed households affected by HIV/AIDS in Ethiopia particularly in Silti Woreda especially to policy makers and service providers. Your presence and participation in this research is imperative to learn and understand the situation. The information I am going to collect will not identify you in any way and you may withdraw from the interview at any time without any negative consequences to you.

SPECIFIC INTERVIEW GUIDE QUESTIONS:

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

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

II. FOCUS GROUP DISCUSSION GUIDE WITH YOUNGER SIBLINGS

INTRODUCTION

Good morning/good afternoon. My name is Nigus Tadesse. I am Master of Arts student at Indira Gandhi Open University School of Social Work. The objective of this study is to explore the situation of child headed households affected by HIV/AIDS in Silti Woreda. As part of my study, I am going to discuss the situation with you. I will use the information I obtain from you to provide a clear picture of the roles and challenges of household care giving in child headed households affected by HIV/AIDS in Ethiopia particularly in Silti Woreda especially to policy makers and service providers. Your presence and participation in this research is imperative to learn and understand the situation. The information I am going to collect will not identify you in any way and you may withdraw from the interview at any time without any negative consequences to you.

POSSIBLE DISCUSSION QUESTIONS

- 1) Because you are an orphan child, have you ever been given any unwelcome naming by people in your community? If yes, let us share the term/s.
- 2) How many households do you know in your community that exist without living parents (both mothers and fathers) and one living parent (either a father or a mother)? Do you have any idea or are you aware of the factors for these households to exist?

- 3) What are the major problems that you are facing in your homes and your main perceived needs?

- 4) What are the major problems you are confronted with in your day to day activities? How were/are life going on before/after the death of your parents? How do you perceive the role of your brother/sister as a child headed household in your home?

- 5) Do you want to add something before we conclude and close our session?

III. INTERVIEW GUIDE WITH KEY INFORMANTS

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

CONSENT

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

_____ Agreed
_____ Not agreed

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

ANNEX B:

INFORMED CONSENT OF GUARDIANS/CARE TAKERS OF RESPONDENTS

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

Signature_____ Name_____

