THE EFFICACY OF CHILD-HEADED HOUSEHOLDS IN CARING FOR ORPHANS IN SLUM AREAS OF ADDIS ABABA

BY

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June, 2015
Addis Ababa
ACKNOWLEDGMENTS

I would like to pay tribute and glory to the Almighty God for granting me the ability and leading my way to a blooming future.

The completion of this research was made possible by the support of Dr. Teka Zewdie through guidance and academic supervision.

I am also very grateful to everyone who participated in the study as respondents and informants. A special word of thanks goes to Child-headed households for their critical inputs into the research.
**ABSTRACT**

This study explores the efficacy of child-headed households in caring for orphans and identifies major roles and responsibilities of these children, as well as the underlying factors affecting children’s household capability and the role of key actors in the provision of care and support for child-headed households. A combination of quantitative and qualitative methods was employed. Despite what is currently known about the factors that result in children assuming the burden of household responsibilities, very little information is known about the efficacy of household-headed children. The findings of the study showed that child headed household orphans often grow up deprived of emotional and material needs and the structures that give meaning to social and cultural life. The distinctive nature of these problems obligated formulating clear policies and evidence based strategies which leads to complementary and synergy among various care institutions. It is often assumed that the presence of child-headed households in communities entails traditional social support system have wrecked down. In spite of multifaceted difficulties, the majority of child headed households appear to be well-adjusted and more responsible than others in their community. Children require support in the care of their siblings by the government and other stakeholders and much more decisive action is needed to ensure consistent care for child-headed households. Children’s capability of running households is imperative inquest which requires solution across multifaceted challenges faced by child-headed household.

**Key words:** Efficacy; Child-headed households; Caring; Orphans in Addis Ababa
ACRONYMS AND ABBREVIATIONS

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<thead>
<tr>
<th>Acronym</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immuno Deficiency Syndrome</td>
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<td>ACPF</td>
<td>African Child Policy Forum</td>
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<td>CHH</td>
<td>Child-headed Households</td>
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<td>CBO</td>
<td>Community Based Organization</td>
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<td>CSA</td>
<td>Central Statistical Agency</td>
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<td>EDHS</td>
<td>Ethiopia Demographic and Health Survey</td>
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<td>FHI</td>
<td>Family Health International</td>
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<td>Faith Based Organization</td>
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<td>FGM</td>
<td>Female Genital Mutilation</td>
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<td>FGD</td>
<td>Focused Group Discussion</td>
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<td>FMOE</td>
<td>Federal Ministry of Health</td>
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<td>FDRE</td>
<td>Federal Democratic Republic of Ethiopia</td>
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<td>GNP</td>
<td>Gross National Product</td>
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<td>JLICA</td>
<td>Joint Learning Initiative on Children and HIV/AIDS</td>
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<td>KII</td>
<td>Key Informant Interview</td>
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<td>MOLSA</td>
<td>Ministry of Labor and Social Affair</td>
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<td>OVC</td>
<td>Orphan and Vulnerable Children</td>
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<td>UNICEF</td>
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<td>MWCYA</td>
<td>Ministry of Women Children and Youth affair</td>
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CHAPTER ONE: INTRODUCTION

1.1 Background of the study

Estimates of the numbers of children being orphaned by AIDS-related deaths in sub-Saharan Africa raised international concern about an ‘orphan crisis’ and the ‘burden’ of their care in already fragile family and community circumstances (Abebe and Aase 2007). More catastrophically than elsewhere, the HIV/AIDS epidemic has deepened poverty and exacerbated myriad deprivations in sub-Saharan Africa. The responsibility of caring for orphaned children is a major factor in pushing many extended families beyond their ability to cope. With the number of children that require protection and support soaring – and ever-larger numbers of adults falling sick with HIV/AIDS – many extended family networks have simply been overwhelmed. Many countries are experiencing large increases in the number of families headed by children and grandparents. These households are often progressively unable to adequately provide for children in their care. The number of children living on the street is rising, most likely driven by HIV/AIDS.

In Ethiopia, there were an estimated 4.2 million orphans in 2013, accounting for approximately 12% of the total child population. Of these, 792,840 (19%) were orphaned due to HIV/AIDS. The 2011 Ethiopian Demographic and Health Survey (DHS) estimates that 25.6% of all households are caring for a foster and/or an orphan child under 18 years of age. Within the Young Lives study in Ethiopia one in five of the older children had lost one or both parents by age 15, and one in ten of the younger group by age 8. As is the case internationally, paternal orphaning is more prevalent. In 2009 5.8% of the younger children and 14% of the older children were paternal orphans; reported maternal orphanhood was 2% and 4%, respectively. Parental absence was even more prevalent: 19 per cent of the younger cohort and 22% of the older cohort reported having absent fathers.

In 2005, Ethiopia had the fourth largest orphan population in sub-Saharan Africa (CSA, 2010). More than five million children aged 17 or younger, more than 6% of the total population, were one-parent or double orphans (FHI, 2010).
Approximately 2.4 million were maternal orphans, 3 million were paternal orphans, and more than 600,000 were double orphans (Tsegaye, 2008, p.20). AIDS-related deaths accounted for 530,000 maternal orphans and 465,000 paternal orphans (Tsegaye, 2008). Approximately 77,000 households were headed by children (CSA, 2005). A National wide survey in 2006 found that the proportion of AIDS orphans among all children aged 0-18 years was 14.7%, 16%, and 7%, in major cities, small towns, and rural areas, respectively (MOLSA et al., 2006), suggesting that a significant section of the child population in Ethiopia is severely affected by the AIDS pandemic. The same study revealed that most AIDS orphans were unable to sustain their lives as before. The majorities are expelled from their parental residence and resort to living with relatives, friends, neighbors or on the streets. Others are hired as house servants, and are vulnerable to lack of care, love, affection, support and follow up. The extremely rapid rate of orphanhood and destitution among children makes it difficult for families and communities to respond in a traditional manner of taking these children into extended families. The situation has led to the emergence of a new form of a family structure: a household headed by one of the affected children, or simply a child-headed household (CHH).

Gilboume (2001) refers to a phenomenon where children live in situations without adult care in the home as child-headed households. But a more informative definition by Bouwer (2002) states that a child-headed household is a scenario where the parents or adult care givers have died or abandoned the children, and the head of the household is a child under the age of 18 years. Growing up in a child-headed household imposes a number of challenges. Children who live in child-headed homes often have to drop out of school to work and have to worry about where their next meal will come from.

Ethiopians have traditionally fluid arrangements concerning the care and residence of their children who moved relatively easily among the extended family. However, Foster (2003) reports that the family's capacity to do this is being eroded by a dramatic increase in the number of orphans, and a reduction in the number of prime-age care givers, such as aunts and uncles. The phenomenon of Child headed household is complex and multifaceted. It impacts on the societal framework and has profound implications for the well-being of children and the realisation of their rights. It disrupts family and community functioning and affects the rearing and development of children.
For the purpose of this study, a CHH was recognised as a situation where a child had taken charge of a household in terms of decision-making and responsibility to provide for the physical, social and emotional needs of others living with him/her in that household. In evaluating the situation of child-headed families in Ethiopia one could question their efficacy in caring for orphans.

1.2 Statement of the problem
AIDS has a profound impact on social development in Ethiopia. Economic growth and income suffer, and poverty is thus exacerbated. We know that there is a reciprocal relationship between HIV and poverty – on the one hand, HIV has significant negative economic implications, while on the other hand, economic factors drive the expansion of the pandemic (Whiteside, 2008). At societal level, there is consensus that AIDS has macroeconomic implications, such as a reduction in economic growth. It is at the level of households, however, the impact of AIDS is seen most starkly – there is a close relationship between a household being affected by HIV/AIDS and its subsequent impoverishment, with children being particularly vulnerable. HIV and AIDS have far reaching effects “beyond individual infection, illness, and death; the pandemic is evidently undermining social structures that sustain rural livelihoods” (Murphy, Harvey, & Silvestre, 2005, p. 265).

Recent literature is almost unanimous that institutional care is undesirable (UNICEF, USAID, & FHI, 2002). Tolfree (2003, p. 5) advances ten reasons why this is so: “the segregation, discrimination and isolation that institutionalized children often experience; the fact that admission is often based on the needs of parents, not the interests of children; the lack of personal care and stimulation; the lack of opportunities to learn about the roles of adults; the high risk of institutional abuse; the lack of attention to specific psychological needs; and finally, reflecting all of these features, the fact that institutionalized children often experience problems in adjusting to life outside of the institution.”

Those literatures argue for the placement of orphans with the extended family, a pattern of informal fostering that is prevalent in Africa, even among non-orphans. However, there is a growing body of evidence that shows the resources and capacity of the extended family to provide such care is rapidly and dramatically waning (Boris, Thurman, Snider, Spencer, & Brown, 2006). Thus, what happens to orphans who can be taken up neither into institutional care nor into foster care? The challenge is who should look after these orphans?
The answer is that most of these become ‘child-headed households’ and the data suggest that these households in Ethiopia are on the increase (UNICEF et al., 2008).

The household is considered to be the basic social and/or economic unit of society. Changes at the household level, therefore, have repercussions at the aggregate level of a country. For instance, changes in household composition and structure have an impact on the distribution of goods and services, and on the planning of community institutions, requirements for schools, housing and health infrastructure.

Given the crucial and vital role that households/families play in the harmony and development of society, it is evident that the necessary concern should be shown for the well-being of such unsubstitutable social institution.

The efficacy of child-headed households to perform basic household function is one of the most important concerns. When households are headed by children, it is generally hypothesized that these households are more likely to be economically deprived and lack the proper emotional environment for psychosocial development of children. Recently there is an impetus for increased research on orphan headship arising from the premise that child-headed households embrace a sub-population which may be potentially vulnerable to social and economic hardship.

Thus, child headship is a concept that attracts policy attention as a social and economic issue in many cases. Since a substantial segment of child-headed households are "adult less" households or households with no permanent adult resident contributing to household income, child headship may imply a heavy economic burden on children who have the responsibility of maintaining the households. The situation is assumed to be particularly critical in Ethiopia where social welfare systems which could support this group are nonexistent or inadequate.

Although the study of the efficacy of child-headed household is becoming important and is given a fairly new emphasis among children issues, evidence from recent studies suggests that African children have remained somewhat ‘peripheral to the AIDS response’ (JLICA, 2009 p.4). Indeed, research by the joint learning initiative on children and HIV/AIDS (JLICA, p 9-10) has revealed major flaws in the response to date, namely that:

1. **Poor families are supporting orphaned children with minimal assistance, including from their governments**;

2. **Community responses are poorly understood and supported**;
3. Implementation of key services falls short of needs; and

4. National political commitment and resources are insufficient.

It is the belief that researches on areas of children and development should give special priority and concern to child heads and their households. Moreover, children of child-headed households are assumed to be in a more difficult situation than children from other types of households. It is to assess the situation of such child-heads and their households and empirically asserting whether children who head households are effective to care for their fellows or not.

1.3 Objectives of the research

1.3.1 General objective

- To assess and examine the efficacy of Child-headed households in caring for orphans and identify successful child-headed households.

1.3.2 Specific objectives

- To identify the major role and responsibilities of household headed children
- To assess the capability of household-headed children
- To identify the major contributing factors that affect efficacy of child-headed households
- To identify the role of different stakeholders in the provision of care and support for child-headed households

1.3.3 Research questions

1. What are the major household roles and responsibilities assumed by child headship?
2. How do household headed children perceive their capability?
3. What are the major contributing factors that affect efficacy of child-headed households?
4. What are the roles of different actors in the provision of care and support for enhancing efficacy of child-headed households?
1.4 Significance of the study
An emerging body of research is beginning to show challenges and phenomenon on child-headed households in Africa. Recent studies conducted in South Africa, Tanzania, and Zimbabwe have all demonstrated that overwhelmingly “new generation of child-headed households” in Africa who faced multifaceted challenges. Hitherto, to my knowledge, no study has been conducted on the efficacy of child-headed households in Ethiopia and elsewhere. The information derived from this study would be used by organizations to enrich the knowledge they have about the efficacy of child-headed households. Above all, the research finding will be used as a reference for those researchers who want to do their investigation in similar theme. Lastly, the researcher will make every effort to employ research findings for child-headed households and orphans at large.

1.5 Limitation of the research
One of the major limitations faced by the researcher was time constraint due to regular office work and many other commitments as a full time worker during the course of the study. Besides, shortage of finance, unavailability of enough materials around the research question where pertinent limitations.
1.6 Operational definitions

Child refers to a person who is under 18 years of age (MWCYA, 2004).

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

Household In terms of its composition, this study has taken a household as being headed by a child, composed of at least one or more members/siblings less than 18 years of age in the same dwelling unit.

Orphan refers to a child less than 18 years of age without parents. In this study orphan refers to double orphan whose parents have died from HIV/ AIDS.

Efficacy is the ability of household head child to influence his or her environment to foster the orphans development and success.

Caring refers to behaviours and practices of child headship to provide food, stimulation, health care and emotional support necessary for children’s health growth and development (Engle, 1983).
Chapter Two: Review of related literatures

2.1 Background, Definitions and Prevalence

2.1.1 Child headed households

Although there is no well documented evidence in Ethiopia, it is often argued that child-headed households are a new phenomenon, first recorded in Uganda in the late 1980s (Weselwiep, 2005:1) and Tanzania (Mukoyogo and Williams 1991). In 1991, such households were observed in Lusaka, Zambia (Ham 1992), Manicaland, Zimbabwe (Foster et al. 1995) and, for the first time, in six villages in the Masaka district of Uganda, where previously no such households had been noted (Naerland 1993). In the United States, cases of teenagers caring for younger siblings after deaths of parents from AIDS were reported in 1993/94 (Levine 1995:194).

Circumstances leading to households becoming ‘child-headed’ in sub-Saharan Africa are linked to HIV/AIDS (Germann, 2005; Ayieko, 1998), and/or armed conflict (for example, the 1994 genocide in Rwanda). The small amount of research on child-headed households shows that children in child-headed households are often poorer than children in adult-headed households (Strode, 2003; Bless, 2005), may be struggling to stay in school (Luzze & Ssedyabule, 2004), have emotional problems related to the death of caregivers (MacLellan, 2005; Strode 2003), and have difficulty accessing social services (Luzze & Ssedyabule, 2004). Although many of these problems may be similar to those of orphaned children or those living in poverty, the problems of children in child-headed households are more extreme and unrelenting (Foster, 2004: 72) and they experience unique problems due to the absence of an adult caregiver (Rosa, 2004: 4).

One such unique problem is that children in child-headed households are also responsible for younger siblings.

Although caring for siblings and doing household chores may be perceived as ‘normal’ in any household, the role of children in child-headed households may go beyond the ‘normal’. Bauman and Germann (2005: 101-103) argue that such children may become ‘parentified’, which entails a role reversal.
When children in child-headed households take on a parental role their responsibilities become much larger. This ‘role-reversal’ may involve a great deal of stress and anxiety in children’s lives. Children in child-headed households are further viewed as ‘deprived’ of parental guidance, support and protection (NMCF, 2001; Rosa, 2004). Consequently, they are more vulnerable to harassment, exploitation, discrimination, and physical and sexual abuse (Rosa, 2004: 4; UNICEF, 2007: 29). Overall, children in child-headed households are viewed as living in extremely vulnerable situations, and as in urgent need of protection and support.

Available information indicated that the concept child household head has been defined in terms of age and role based categories. For example, according to Sloth-Nielsen (2004:1) child household heads are generally considered to be those where the main caregiver is younger than 18 years of age.

Also in Ethiopia, the African Child Policy Forum (2008: 27-28) defined child household heads according to two broad categories: accompanied child household heads and unaccompanied child household heads. The former definition was related to a household where a child is providing income and care to siblings in which the parents or primary caregivers are incapacitated by chronic illness, old age or disability. The latter was given for the household where a child is supporting and taking care of siblings without an adult in the household, because both parents...
have died, cannot be found, are unknown or have given up supporting the children for economic reasons. A child-headed household is defined as a household where everyone who lives there is younger than 18 years of age, i.e. a child-headed household is a household consisting only of children (Children’s Count, 2005). On a homogenous note, UNICEF (2005) holds that a child-headed household is when a child or children take over as the head of their household and fend for themselves without any adult supervision. The emergence of child-headed households is mainly as a result of the death of both parents and the failure of relatives to assume parental duties. The relatives usually do not have sufficient resources to look after the bereaved children. The death of a child’s parent due to an HIV/AIDS related illness means that the child is bound to face social stigma and the community members are often not prepared to provide care and support to these children. It has been noted that the emergence of child-headed households can also be a result of increasing death among adult relatives (Nyawasha, 2006).

Child-headed households that have adult occupants, such as ill parents, underscore the need to make a distinction between child-headed households that include adults (accompanied households), and those that do not (unaccompanied households) (Germann, 2005). Likewise, there is ongoing debate regarding what constitutes heading a household, whether it is on the grounds of moral authority, earnings, decision making or presence in the home and responsibility for day-to-day household functions (Budlender, in Richter, 2004). This is particularly relevant in child-headed households in which an adult resides (an accompanied household). According to Desmond, Richter and Amoateng (2003) a distinction exists between being the instrumental head of a household (de facto headship), and being household head by law (de jure headship). In child-headed households an absent, ill or elderly household member may be the de jure head of the household, whilst the child is the de facto head because of their instrumental responsibilities in the home. In terms of child-headship, Desmond et al. (2003) associate de facto headship with more problems than de jure headship.

This distinction is particularly relevant with regards to children living with their grandparents. When parents become ill or die, the responsibility for their children frequently falls to the grandparents (Foster, 2000). However these grandparents are sometimes ill or weak and the caretaking is reversed with the grandchildren caring for their grandparents (Foster, 2004; Giese et al., 2003). In Germann’s study (2005), one out of five child-headed households included grandparents who required care.
However, in spite of their physical burden on the household, sickly grandparents were also seen to benefit the household by their ability to unite the family, as well as provide advice and guidance. Nevertheless, conflict did exist when the primary caregiver (and ‘de facto’ head of the household) disagreed with the grandparent (Germann, 2005). A more frequent and more distinct presentation of child-headed households is when there is no adult living with the children. Most of these children are orphans, who would usually be cared for by the extended family (Madhavan, 2004). It has been suggested that the existence of child-headed households indicate that the extended family is failing (Foster et al., 1997). Traditionally a strong network of aunts, uncles and grandparents, the extended family might foster children if they could provide better care, schooling and opportunities (Giese et al., 2003; UNICEF, 2003). In times of crisis, for example in parental illness and death, the extended family would provide a safety net and support to vulnerable children (Foster, 2004; Madhavan, 2004). However, the protective structure of the extended family in Africa has been weakened or broken down by a number of factors that have reduced its efficacy in providing support to family members and Ankrah (1994) cites several reasons for this: First, because of migration to urban settings, families have become more nuclear. Second, due to a decrease in financial resources, extended family members are no longer able to offer as much support.

Other factors have also led to the establishment of child-headed households. In particular, if an adolescent had proved whilst the parent was still alive that he or she was capable of assuming the responsibilities in the household, relatives would leave the adolescent to head the household after the death of the parent (Foster et al., 1997). Sometimes the extended family may try to split siblings up to be cared for by different members in order to share the drain on their resources. But separation from siblings can cause emotional distress in children, and children may refuse to move in with relatives in order to stay together and in a familiar environment, such as home and school (Nampanya-Serpell, cited in Richter, 2004).
2.1.2 Psychosocial Effects of Being Orphanhood and Household head

A child heading household will experience various psychosocial stressors, several will be related to the environments in which they live and illness or death of their parents, whilst other impacts will be directly related to being the head of a household. In fact, Foster (2004) argues that the difficulties that children heading their households face, such as poverty, access to education, and psychological difficulties are not unique, but what is unique is that these difficulties will need to be faced largely without adult help, and the stressors are likely to be more severe and prolonged. Research has shown that the prevalence of HIV infection is highest amongst poor households (Shisana et al., 2005), and as the course of the illness continues, the financial struggles of the household tend to be exacerbated. As HIV-positive people become ill, they are less likely to be able to work and the costs associated with their healthcare could increase exponentially (Giese et al., 2003). Thus, as the illness continues and worsens, the household income decreases, whilst the expenses increase, until the point of death which may leave the household impoverished (Foster, 2005; Germann, 2005). In addition, high funeral costs exacerbate the strain (Richter, 2004). This can have far-reaching consequences for the household, such as a lack of money for medical care or for transport to access potential sources of support. Families sometimes resort to reallocating their resources, such as withdrawing children from school, or they may sell household assets (Germann, 2005). This may leave a household in extreme vulnerability as they are left with no reserves or savings (Richter, 2004). As poor households have fewer assets to fall back on, they experience more severe difficulties in trying to cope (SAfAIDS, cited in Germann, 2005).

Children affected by HIV and AIDS may also start working for an income. This is particularly true for girls (Foster, 2004). Although child labor in general is common in Africa (Richter, 2004), orphans are more likely to be involved in work due to the generally poorer conditions in which they live (Foster, 2004). The types of work that children become involved in include domestic work, gardening, farming, hawking, as well as working in shabeens and brothels (Foster, 2004). In the study by Germann (2005), it was found that most children heading a household spent several, if not many, hours dedicated to earning an income for their families; however the pay was generally very low. Renting out part of their property to others was another way to generate income, which was used by most child-headed households in the study.
These responsibilities are considered to be developmentally inappropriate and could lead to long-term emotional problems, disruptions in education and sexual exploitation (Foster, 2004). Research has found that orphans are more likely than non-orphans to be absent from formal schooling (Smart, 2003a). However, it has been argued that low school enrolment is more strongly correlated with poverty than with orphanhood itself. When orphan enrolment is delayed, it appears to be linked to the poor environments in which they live (Ainsworth & Filmer, 2002).

Girls are more likely to be withdrawn from school than boys as investment in boys’ development is presumed to be more beneficial in terms of later income. Furthermore, girls are more likely to be caregivers and as such are assigned these positions to the detriment of their schoolwork (Giese et al., 2003; Marais, 2005). Although the removal of children from school may assist households in the short-term by reducing their costs, and increasing the labor (either outside or inside the home), this is seen to have a negative effect on the efficacy of child headed household in the long-term (Hunter & May, cited in Philipson, 2005). Not only are children in child-headed households less likely to attend school, they tend to have limited family contact, and therefore may not have access to the life skills or cultural knowledge that is usually passed on from the parents and family (Walker, 2002). Furthermore, many children in child-headed households lack access to adequate information, such as information on household management, reproductive health, legal issues to run a household, and care of younger siblings (Germann, 2005). Children affected by HIV/AIDS within the context of poverty, peer pressure and a lack of adult guidance, may become sexually active at an earlier age, be vulnerable to sexual abuse and become involved in commercial sex work (Richter, 2004).

Stigma and discrimination within the context of HIV and AIDS are seen as the primary causes of social isolation, shame, and a lack of emotional and financial support, not only for the individual infected with HIV, but for their families too (Giese et al., 2003). An important aspect of stigmatization within the context of HIV and AIDS is the concept of self-stigmatization (Goffman, in Deacon et al., 2005) whereby individuals avoid situations that they assume will lead to discrimination. For example, some families have chosen not to receive relief packages, or to access health and social services in order to avoid the stigma associated with those packages or services (Giese et al., 2003). Similarly self-stigmatization also disrupts school attendance; as children will stay away in order to avoid discrimination from teachers and peers (Richter, 2004).
Although avoidance is usually seen as a maladaptive response, within the context of HIV/AIDS this avoidance may constitute a realistic evaluation of a situation or community (Deacon et al., 2005). Often the instrumental tasks that children living in a child-headed household experience overshadow the psychological issues that they may experience, but Germann (2005) suggests that the effort of appearing to cope and being ‘invincible’ must be enormous. Research has shown that children with HIV-positive parents can experience heightened anxiety and depression, difficulty eating, and somatisation problems such as headaches, migraines and stomach aches (Pivnick & Villeges, 2000). People with HIV and AIDS can have various mental and psychological difficulties, including mood disorders, dementia and delirium, which may make them emotionally unavailable parents (Freeman, 2004). Giese et al. (2003) found that children experienced that as their parents became more ill, their attitudes towards them changed, with children perceiving their parents not caring about them, being angry and sometimes dismissive towards them. This was very distressing for the children, sometimes resulting in children staying on the streets rather than going home. Furthermore an ill parent may target their anger and disappointments in life at their children, which can result in the children feeling incompetent and unworthy of love and affection, which may lead to poor self-esteem (Winton, 2003).

2.1.3 Role and responsibilities of child headship

In order to assess the appropriateness of responsibility a child assumes within a child headed household, a hypothetical continuum consisting of four types of roles has been developed by Jurkovic et al. (1999): This includes infantilisation, healthy non-parentification, adaptive parentification, and destructive parentification. When a child does not assume any age-appropriate responsibility and is dependent on the care of their parents, this is known as infantilisation. Healthy non-parentification is where children are assigned age-appropriate tasks in the home, but rigid roles are not placed upon them. Adaptive parentification refers to when a child is thrust into a parent or adult role during a crisis and for a short period only. In addition, the effort of the child is recognized and acknowledged as a role outside of what is normally expected of him or her. Destructive parentification is defined as excessive responsibility for a child, both in duration and extensiveness, such that it seriously impinges on the child’s development, and the child does not receive recognition and support for his or her efforts (Barnett & Parker, 1998).
Parentification has also been delineated into different types of responsibilities or roles assumed by (Mika et al., 1987): Non-specific adult role-taking includes household chores, such as laundry, making dinner, cleaning the house, and doing dishes. Spousal role vis-à-vis parent involves the sharing of intimate secrets, personal problems and financial issues of the parent as if the child is another adult. A parental role vis-à-vis sibling refers to caring as well as disciplining his or her siblings as if the child were their parent. Parental role vis-à-vis parent involves the parent asking for input on decisions, seeking advice on adult matters, and receiving care when physically ill from the child. It has been suggested that when a child acts as a parent to their parent, it is a role-reversal, and is potentially a more detrimental form of parentification because in addition to limiting the child’s development because of the age-inappropriateness of the role, it also affects the next generation because of the repetition of this family pattern through to the next generation (Barnett & Parker, 1998).

Another distinction has been made between instrumental and expressive parentification. In instrumental parentification, a child is involved in practical tasks, such as cooking, cleaning, and physical cares of those he or she parents, and sometimes earning an income. In expressive parentification, which is seen to be more threatening to a child’s well being, a child is attuned to the emotional needs of whomever he or she is caring for, and will provide emotional support, or be a peacemaker or mediator as required (Jurkovic, Jessee, & Goglia, 1991). It has been proposed that in middle to upper class families, children are more likely to display expressive parentification behaviours because there is enough money to hire external help (such as cooks) for the instrumental tasks (Winton, 2003). It is likely that children in households affected by AIDS may present with both instrumental and expressive parentification, by assisting with the household tasks and earning money for the household, as well as providing emotional support for household members.

2.2. Factors affecting the efficacy of child headed households

My review of literature identified key themes regarding the factors affecting efficacy of child-headed households. This will focus on: role adjustments, social security, emotional and social distress, economic challenges, food and nutritional needs, and education and schooling.

2.2.1 Role Adjustments

Following the death of their parents, children must make the adjustment from being a child to being the head of a household, an adjustment that carries many challenges. Nkomo’s (2006)
study in Gauteng and Kwazulu-Natal identified several key components of this adjustment, including the feeling of having lost one’s childhood and sense of self with the attendant feelings of deprivation; of responsibility towards one’s family (younger siblings) and the obligation to take the place of the deceased parents; of being abandoned by extended family members who they feel should be taking responsibility for them; of concern for surviving in the face of economic hardship; of grappling with multiple and competing responsibilities; and of helplessness and uncertainty about personal safety, family disintegration and discipline.

Mkhize’s (2006) study in Kwazulu-Natal also highlighted the multiplicity of adult roles that the heads of child-headed households undertake, notably decision making, leadership, economic provision, care giving, conflict management and housekeeping. Children in her study reported that it was stressful to carry these roles. A study of child-headed households in India similarly reported that the adjustment of children into the household head role was very challenging (India HIV/AIDS Alliance & Tata Institute of Social Science, 2006).

A study in Gauteng found that role changes and role overload were significant concerns for child household heads (Masondo, 2006). Major roles included being breadwinner, caring for younger siblings on a daily basis, providing emotional support to their bereaved siblings, enforcing discipline and structure in the household and making decisions about the family. All of these roles would previously have been carried by their parents and must now be taken up the child head of the household.

2.2.2 Emotional and Social Distress

Orphanhood is associated with psychological and emotional trauma, as well as social distress. A study in Uganda found that, when other variables were controlled, orphaned children evidenced higher levels of psychological distress than matched non orphaned children (Atwine, Cantor-Graae, & Bajunirwe, 2005). The researchers concluded that more than just material support was needed – counseling and psychological/emotional support were also required.

2.2.3 Economic challenges

Studies suggest that child-headed households are much more economically vulnerable than adult-headed households.

A small qualitative study in Kwazulu-Natal found that children in child-headed households survived on about a third of the resources (money and in-kind gifts of food, etc) compared with similar adult-headed households (Donald & Clacherty, 2005).
The research found that in adult-headed households, adults carried sole responsibility for income generation – no children carried this responsibility. Children in child-headed households earned money through activities such as conducting taxis and washing clothes, braiding hair and selling single cigarettes. A number of children also worked for payment in kind – doing household work, fetching water or making mud bricks.

2.2.4 Food and Nutritional Needs

Food security is defined by the World Bank as “access by all people at all times to enough food for an active, healthy life” (Schroeder & Nichola, 2006, p. 173). Poverty is, naturally, the main determinant of food insecurity. Although this study did not address child-headed households, another study in Congo affirms that child-headed households do have lower levels of food security than the general population (Roger, Fabrice, & Aminata, 2006).

2.2.5 Education and Schooling

Education is one of the facets of the life of a child that is threatened by HIV and AIDS and by child-headed households in particular (Goldstein, Anderson, Usdin, & Japhet, 2001). Children often drop out before they are orphaned, when their parent (often their mother) is too ill to work and take care of the family (Yamba, 2006). When a parent is dying or has died of AIDS, social stigma acts as an additional stumbling block to the continued education of the children (Ayieko, 1997; Masondo, 2006), some of whom report being bullied and harassed (Robson & Kanyanta, 2007). Household heads are particularly vulnerable to dropping out of school in order to care for their younger siblings who continue with their education (Masondo, 2006). OVCs often cannot afford to continue schooling and have to spend their days eking out survival (Ayieko, 1997; Richter, 2004).

The cost of schooling is not restricted to school fees (which are sometimes waived), but also to learning materials (e.g. books and stationary) and school uniforms (Yamba, 2006). “Child-headed households are often extremely vulnerable and impoverished, driving children into work and preventing them from attending school” (Robson & Kanyanta, 2007, p. 419)

2.2.6 Social capital

Social capital is perceived as a vital part of livelihood strategies. The notion of social capital in the livelihood approach and the propagated community-driven development approach are closely related. They both start with the view that poor people may not have income, but can be resourceful in employing survival strategies and are part of mutual help and support systems
González de la Rocha refers to this view as “the myth of survival” in which poor people are perceived as able to “implement survival strategies that are based on their endless capacity to work, to consume less and to be part of mutual help networks” (2007: 45). González de la Rocha focus on the social relationships and community safety nets of poor people may result in ignoring the real issues poor people face: high unemployment rates, insufficient housing and health care, among others.

Nonetheless, children may depend on these social relationships for their daily survival. However, it should never be assumed that children in child headed households are sufficiently supported by neighbors or relatives. Phillips’ definition of social capital may be useful in this sense: she defines social capital as “the relationships and networks developed and drawn upon by the urban poor to survive and improve their livelihoods” (2002: 133). Seen in this way, the value of social capital depends on “its ‘use value’ and ‘liquidity’ in the specific social context in which it is found” (Foley & Edwards, 1999: 146).

The assumed connections or relationships may be very important for children living in child-headed households, as they do not have immediate support from resident parents or grandparents. What is unknown, however, is how these are actually contributing to children’s safety nets and access to resources.

2.2.7 Social security

Most African countries including South African government provides the child support grant and foster care grant for children in need, provided that an adult is present in the home (thus in the case of child-headed households, an accompanied household). Even those children who are eligible for grants actually receive them, due to a lack of awareness surrounding the grants, lack of necessary documentation, administrative delays and the poor service of government personnel (Foster, 2004; Giese et al., 2003). At this stage, children living alone in unaccompanied child-headed households are not able to access social grants for two reasons: First, the law requires that a primary caregiver is an adult, and second, in the case of a foster care grant, it is only accessible by an individual who, by a court order, has been granted fostership of a child (Rosa, 2004), which precludes the informal fostering by another child. This means that the grants exclude some of the most vulnerable children (Foster, 2004; Rosa, 2004). Other than these grants, the South African government provides food packages for those people who need immediate help to survive. However, the value of these packages is less than the value of the
grants, and can only be given to a household for a maximum of three months (Foster, 2004). Although Ethiopia adopted laws that protect children against the violation of their fundamental rights and develop social welfare policy, provision of child support and foster care grant for children in need were totally absent. There is only the State Old Age Pension for people over the age of 60 who were civil servants. In Ethiopia most formal support for HIV/AIDS affected households was through non-governmental organizations (NGOs) and community-based organizations (CBOs). However, these are seen to be fragile structures as they are run mostly by volunteers and donor driven agendas and time frameworks.

There are no specific legal frameworks concerning the care and support to be given for child headed household. For instance, immediate measures to be taken by the condition 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 immediate caregivers and their relatives at large.

2.2.8 Childhood resilience and coping

Both research on child-headed households and research on parentification warn of the potentially damaging outcomes for the children in these circumstances. However, it has been estimated that out of all children who are exposed to extremely disadvantageous situations, less than a third will be adversely affected whilst another third will thrive, be well adjusted and achieve good intellectual standards (Richter, 2004). Specifically with regards to children affected by AIDS, appear to be functioning better than expected (Pharoah, 2004). It has been suggested that this ability or skill could be, in part, the result of a child’s resilience and coping skills.

When a person is confronted with a stressful situation, he or she appraises what resources are available to deal with the situation. The extent to which individuals believe they can deal with the situation is referred to as their ‘self-efficacy beliefs’. Coping is an iterative process, in which self-efficacy beliefs affect coping strategies and coping outcome, and self-efficacy beliefs influence the contextual factors.

Although the distinction between coping and resilience is unclear (Germann, 2005), it appears that coping is typically a short-term mechanism to deal with a specific problem, whilst resilience is a more enduring feature of an individual’s character. Lazarus and Folkman (1991) define coping as “realistic and flexible thoughts and acts that solve problems and thereby reduce stress” (Lazarus & Folkman, 1991, p. 190). However, they extend their definition of coping to include
processes or efforts to manage emotions and maintain self-esteem when faced with problems, regardless of the outcomes, as not all problems are solvable (Lazarus & Folkman, 1991). Resilience can be defined as the process of, or capacity for, successful adaptation despite challenging or even extremely threatening circumstances (Masten, Best, & Garmezy, 1990).

Research on resilience has found that there is not one single factor but usually an interlinking of factors involved in maintaining social and psychological health in spite of conditions that would ordinarily result in severe trauma (Bray, 2004). In children, these factors include the child’s personality and temperament, their learned coping style, their age, support available from adults in their environment, as well as opportunities for achievements and new relationships in their current (or new) environments (Richter, 2004). Conversely, the factors related to a child’s maladjustment include if the stressors are chronic and cumulative, and if children have few opportunities for supportive experiences. This emphasizes that a child’s recovery or maladjustment is more dependent on the contexts of the stressors than the type and severity of the stressors (Rutter, 1981 in Richter, 2004).

Parents exert a significant influence over a child’s development of resilience, with the quality of care that children receive as infants having a direct bearing on later resilience (Bowlby, cited in Germann, 2005). Resilience is enhanced if parents are supportive, set rules and routines for behavior in the home, and act in ways that promote stability and cohesion of the family (Werner, cited in Richter, 1994). Critical for resilience, it appears, is a child’s relationships with caring others, not only parents but also being part of social networks and social institutions (Luther & Zigler, 1991). For this reason, culture is also a strong determinant, in that children in communities with strong extended family ties are less affected by adverse situations than those in families with few or no networks beyond their immediate home (Richter, 2004). What seems noteworthy, however, is that although children in adverse circumstances do not have extensive caring and supportive networks, they appear to seek out positive experiences and caring others, such as a teacher, who can compensate for this lack (Richter, 2004). Therefore, even in situations of great adversity, children seek out experiences that will encourage resilience and coping, and it is only in severely deprived situations where no adult support is available, that the worst impacts will be felt (Richter, 2004). Resilience does not seem to be purely a fixed characteristic. Studies have found that it can be developed over time, through coping with successive stressful situations to establish feelings of mastery (Killian, 2004). The opposite is true as well, however,
in that failure in the face of stressful or high-risk situations could lead to a decrease in resilience and consequent increase in vulnerability (Killian, 2004). Therefore, a balance is necessary between experiences that strengthen and experiences that weaken a person. Related research suggests that coping strategies are either problem-focused or emotion-focused (Folkman & Lazarus, 1991). Problem-focused coping is when an individual deals actively with the problematic situation by seeking to change it or by getting help to deal with it. Emotion-focused coping usually occurs when an individual assesses that they do not have the internal or external resources to deal directly with the problem, but will instead attempt to deal with the emotional stress of that problem. Although both problem-focused and emotion-focused coping can occur concurrently, usually one is in the forefront. However, for successful long-term adaptation, an individual should be able to draw on either of these strategies (Germann, 2005). Like resilience, coping is improved if there is social support available, in terms of practical, material, informational, spiritual and emotional support. This assists an individual to deal effectively with the problem, in a problem-focused coping manner. A lack of this type of support can lead to an individual’s excessive use of emotion-focused strategies (Germann, 2005). According to Marais (2005) coping strategies that vulnerable households employ are usually short term, and do not take into account the long-term consequences of these approaches. Examples of these include withdrawing children from school, selling household assets, taking on further debt, and allowing land to lie fallow.

2.2.9 The extended family

Families in traditional societies typically involve a much larger network of connections among people, enveloping the household in relationships that include multiple generations, extend over a wide geographical area and are based upon reciprocal rights and duties. The term extended family places special emphasis on the role of relatives outside the household in providing economic and social support to survivors from AIDS-affected homes. (Foster 2002:4)

It is often stressed that members of the extended family will take care of children who have lost their parents. This is because the ultimate goal of the extended family is the survival of the family as a group (Meursing, 1997: 205). Child rearing in the past was consequently the collective responsibility of the traditional extended family (Mkhize, 2006: 187). A child was socialized by the whole family and community and he or she could be corrected or disciplined by
any adult (Barolsky, 2003: 30). Grandparents particularly played an important role in socialization of children, and older siblings were also expected to play an important role in caring.

The family ties were strengthened by regularly visits to family members and coming together for a prayer or a ceremony (Mkhize, 2006: 187). Because the extended family structure is viewed to be weakened, it is often argued that these structures need to be supported and strengthened.

2.3 Theoretical framework

2.3.1 Effects of child headship and dimensions of support

The negative effects of child headship on children psychosocial wellbeing was repeatedly raised by researchers. Proper continuum of care and support should be considered to minimize the devastating consequences associated with child-headed households. This section particularly gives emphasis on different dimensions of child development and supports, in particular as theorized by Erikson’s psychosocial and Urie Bronfenbrenner ecological theories.

Erikson’s developmental theory

Erikson’s (1959) theory is frequently consulted when looking at emotional and social development, not only because his theory takes into account stages beyond childhood, but because it is seen to be culturally and socially sensitive. His model of psychosocial development has also been applied to the developmental consequences associated with child headship (Fullinwider-Bush & Jacobvitz, 1993). According to Erikson, an individual faces particular developmental tasks or crises at particular stages of their life, and successful resolution of a stage is necessary to continue to the next stage of development (Erikson, 1959). Therefore it is not possible to skip a stage and move to a more advanced level of development without negative implications.

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. 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).

The stage of adolescence is marked by the crisis of ‘identity versus role confusion’ whereby the individual has more diffuse roles, and can experiment in order to find a niche that suits him or
her (Erikson, 1959). At this stage an individual shifts away from the influence of home and parental figures, and his or her friends or peers become paramount.

This social awareness is critical to adolescents as they try to relate their own identity to that of others, in particular to the identity of their peer group (Erikson, 1959). At this stage an adolescent is “more or less retarded in his/her psychosexual capacity for intimacy and in the psychosocial readiness for parenthood” (Erikson, 1959, p. 119).

It is only after a sense of identity has been reasonably established, therefore after adolescence, that the developmental focus shifts to relationships (with the crisis of ‘intimacy versus isolation’) and later, to becoming parents (with the crisis of ‘generativity versus stagnation’) (Erikson, 1959). For the adolescent whose environment does not allow for this experimental phase, but instead demands physical intimacy, occupational choice, competition, and psychosocial self-definition, he or she is likely to experience acute identity confusion (Erikson, 1959). This identity confusion is characterized by an individual who does not have a sense of self, or a sense of his or her belonging or function in the world (Sadock & Sadock, 2003).

It could be argued that Erikson would see child headship of adolescents in child-headed households as implicitly denying this stage of experimentation and requiring the individuals to disregard the importance of identity development. Instead, the adolescents may be forced into intimacy issues (with a remaining parent) and parenting issues (with their siblings and possibly parents), which are consistent with the developmental stage of an older individual. Furthermore, parental role may require an adolescent to seek employment to support his or her family, in which case they may be forced into making an occupational choice, which could further impair identity development. Conversely, Erikson’s theory may also explain a child’s motivation for taking on a parentified role (Chase, 1999). At least temporarily, the parentified role corresponds to the child’s developmental need to be useful and functional, particularly during Erikson’s ‘initiative versus guilt’ and ‘industry versus inferiority’ stages. However, if the parentification role is overwhelming, the child will not be able to perform and will not feel that they have shown initiative and industry, but instead will feel the inverse - guilt and inferiority (Chase, 1999; Earley & Cushway, 2002).
**Ecological/Person–in–environment theory**

Ecological systems model was conceptualized by Bronfenbrenner (1979) to explain how child growth and development is affected by everything in their environment. The relationships between individuals and their environments are viewed as "mutually shaping".

Ecological systems model, also known as “development in Context”, views individuals as being embedded in five types of nested environmental systems, with bi-directional influences within and between the systems (Bronfenbrenner 1979). Each system contains norms, roles and rules that shape development. The systems are microsystem (individual/community or small level), mesosystem (community level/medium level), macrosystem (national or societal), and chronosystem. The interactions that occur within and between the overlapping ecosystems influence each other (Bronfenbrenner 1979). How a system interacts with a child will have an effect on how the child grows and how the child acts or reacts to the system will in turn affect how they react to the child.

In his most recent conceptualization of bio-ecological model, he explains that development takes place through processes of progressively more complex interaction between an active child and the persons, objects and symbols in its immediate environment (Bronfenbrenner 2004). He points out that a child’s development is determined by what she or he experiences in the settings where time is spent and for the interactions to be effective, they should take place regularly over extended periods of time.

The ecological model helps in developing policies and programs that can benefit children and more particularly in the case of this study are those children in Child-headed households. According to Bronfenbrenner, childrearing requires public policies that provide opportunity, status, resources, encouragement, example, stability, and above all parenthood, primarily by parents, but also by significant other adults in the child’s environment both within and outside the home (2004).

Macrosystem describes the culture in which individuals live. Intervention at the macro level includes improving nutrition, housing and access to education, reducing economic insecurity, strengthening community networks. The most effective interventions are those that combine nutritional interventions (such as complimentary feeding, growth monitoring, food
supplementation) with counseling and psychosocial care (e.g. warmth, attentive listening). Such programs are also cost effective (WHO, 2002).

**Meso and Micro level interventions**

**The early stages of life**

There is more development in mental, social and physical functioning during the early stages of life than in any other period across the lifespan. What happens from birth to age three influence how the rest of childhood and adolescence unfolds (UNICEF, 2002). A healthy start in life greatly enhances a child’s later functioning in school, with peers, in intimate relations and with broader connections with society. The major dimensions of a healthy start of life are social, physical and psychological well-being. Factors that can negatively affect these are poverty, physical disease, neglect, poor nutrition and HIV/AIDS in the family (WHO 2007 & UNICEF, 2005). Early traumatic events and lack of care and sensitive responsiveness by parents can harm the neurological development of such systems leading to chronic vulnerability to stressful conditions. The child’s psychological well-being including cognitive skill, coping with stress, emotional resilience and sense of mastery changing dramatically during this time as the child interacts with the environment.

The child’s sense of empathy and sense of right and wrong are also established. Policies targeting family well-being, such as policies to alleviate economic hardship, orphans-friendly policies to provide access to childcare can lead to overall mental and physical health improvements in children and future adults.

**Parenting interventions**

There are effective preventive interventions for children who present with different psychosocial problems (WHO, 2005). Guardian’s management training, for example, provides a behaviorally based intervention that increase positive interactions and reduce coercive interaction cycles between the child and the parent. Studies found out that school achievement was enhanced along with improved behavior after studying such programs.
Pre-school educational interventions

Community programs that can be very helpful for orphans include: healthy screening, organized recreation activities. Evaluation of such programs had resulted in improved cognitive development, better achievement and school completion and fewer conduct problems and arrests than the control children in a randomized study (UNICEF, 2002).

School settings

It also reflects the fact that in addition to their central role of fostering academic development, school serves an important role in the health and socio-motional development of orphans.

To become well-rounded individuals, effective citizens and healthy adults, children need to develop social and emotional competencies. They also need the confidence to use these skills constructively and opportunities to enact their skills in order to facilitate the development of a sense of identity. This process, often called ‘social and emotional learning” (SEL), is the means by which children acquire the competence to understand, manage and express the social and emotional aspects of their lives in ways that enable the successful management of life tasks.(WHO, the Ottawa charter for health promotion, 1986, p12-23)

2.4 The Impact of the AIDS-Epidemic on Trends of child-headed households in Ethiopia

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. AIDS however, will push the number of orphans in the region to more than 53 million by 2010 (UNICEF 2005).

In Ethiopia, there were an estimated 4.2 million orphans in 2013, accounting for approximately 12% of the total child population. Of these, 792,840 (19%) were orphaned due to HIV/AIDS. The 2011 Ethiopian Demographic and Health Survey (DHS) estimates that 25.6% of all households are caring for a foster and/or an orphan child under 18 years of age. All OVC are at increased risk for neglect, abuse, malnutrition, poverty, illness and discrimination and as they get older, are at increased risk for HIV infection. Overall, girls suffer more than boys by not being able to attend school, having to care for others and being forced into early marriage.
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. Some estimates from early 2005 put the figure as high as 100,000 households, in which case 10 in every 1,000 households in the country would be headed by children. According to this estimate, there are nearly half a million children who rely solely on their siblings for love, security, protection and survival.

In addition, in 2008 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. The Ministry of Health report on AIDS in Ethiopia showed that an estimated 1,156,600 people aged 15 and over were living with HIV in 2005, or 3.5 percent of all people aged 15 to 49 in the country. As of 2007, only 24 percent of people living with HIV have access to ART, meaning that the majority of the remainder may be bedridden or otherwise incapacitated. This further strengthens the assertion that children in such households bear the brunt of household headship and management.

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.

In making the statistically valid assumption that children orphaned by AIDS are more likely to end up in child-headed households, a sharp rise in the number of child-headed households in Ethiopia is to be expected in the years to come.
Table 1: Number of Unaccompanied Child-headed Households in Ethiopia

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of CHHs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oromiya</td>
<td>27,726</td>
</tr>
<tr>
<td>SNNP</td>
<td>23,813</td>
</tr>
<tr>
<td>Amhara</td>
<td>10,636</td>
</tr>
<tr>
<td>Addis Ababa</td>
<td>4,385</td>
</tr>
<tr>
<td>Afar</td>
<td>2,778</td>
</tr>
<tr>
<td>Tigray</td>
<td>2,520</td>
</tr>
<tr>
<td>Somali</td>
<td>2,460</td>
</tr>
<tr>
<td>Benishangul-Gumuz</td>
<td>1,398</td>
</tr>
<tr>
<td>Gambella</td>
<td>1,033</td>
</tr>
<tr>
<td>Harari</td>
<td>337</td>
</tr>
<tr>
<td>Dire Dawa</td>
<td>314</td>
</tr>
<tr>
<td>Total</td>
<td>77,400</td>
</tr>
</tbody>
</table>


2.5 Social Support Mechanisms for child-headed households

The multidimensional impacts of HIV/AIDS are widely recognized, governments, civil societies and others have made efforts to challenge the impact of the epidemic by setting different mechanisms in place such as provision of care and support.

A community-based care is one where the children remain in their household but are looked after by various community members and structures like NGOs and CBOs. This model of care builds on the principles of family preservation. This section reviews the existing social support mechanisms that are available to scale up the efficacy of child-headed households in Ethiopia.

2.5.1 The role of NGOs to promote the wellbeing of child-headed households

Available information indicated that children-focused NGOs in Addis Ababa have taken the initiative to provide care and support services to child-headed households. According to a Ministry of Justice Report, these NGOs rendered services at grassroots in the following seven focused areas:

- Educational support including school fees, school uniforms and tutorial support;
- Psychosocial support such as counseling, home visits, recreational support, peer education, life skill training, succession planning and family reunification;
- Health services including medical support, personal hygiene and environmental sanitation, reproductive health services, vaccination, HIV counseling and testing and Antiretroviral therapy;
- Livelihood support such as economic strengthening activities (ES), vocational and basic business skill training (BBS) and provision of seed capital, agricultural inputs and subsistence financial support;
- Advocacy and awareness raising with an emphasis on child protection;
- Food support through the provision of supplementary food and food rations (safety net);
- Early childhood development (ECD) including clothing and therapeutic feeding.

The majority of children-focused NGOs were engaged in education, psychosocial, and health related support while some children-focused NGOs were engaged in interventions including advocacy and awareness raising, food support as well as livelihood related interventions. A few of them were involved in childhood development intervention programmes.

2.5.2 The role of community based organizations

Community based organizations locally called “Iddir” initially established for the sake of funeral activities. However; now a day’s an overwhelming and complicated problems and interwoven challenges among the communities urged them to revise their bylaws and they stretched their efforts to developmental activities apart from funeral activities. The community based organizations are well accepted and respected by the society which facilitate in mobilizing the local communities and resources in collaboration with non-governmental organization. Community based organizations provide various types of services including educational material support, psychosocial support, life skill training, legal protection education, nutritional support (specially during holy day) and school enrollment support.

2.5.3 The role of caregivers and guardians

According to the literature, the immediate family and community members, by virtue of proximity and relationship, would provide care and support through community support groups, mentorship, socialisation, intergenerational skills transfer, participation in advocacy on children’s rights, safety and security.
The caregivers visit the children in CHHs on a regular basis to provide psychosocial support to the head of the household and around household activities such as homework, household chores, basic parenting skills, access to legal documents, and assisting with inter- and intra-personal life skills. Most NGOs take initiative for involving caregivers in poverty reduction activities, such as production gardens and ensuring that siblings are not separated.

2.5.4 The role of Government/ policy makers

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. The government has an obligation to provide care and support for all the children to ensure that children develop to maturity. In the case of CHHs, the circumstances under which these children live compromise their rights.

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).

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. Ethiopia was absolutely strange to different types of social grants including disability and foster care grants. For instance, South African government respond to the financial needs of children through the Department of Social Development (2004) by providing different types of social grants, including:

- **Disability grant**, which pays assistance to people disabled either permanently or temporarily. People infected with HIV/AIDS may apply for this grant.

- **Social relief or distress grant**, which enables families, including CHHs, to meet their own or their family’s most basic needs.

- **Foster care grant**, which is made available to people to enable them to look after children who are not biologically related to them.
• **Cared dependency grant**, which provides financial assistance to parents or caregivers of children from birth to 18 years of age.

• **Child support grant** provides some assistance to a primary caregiver like an extended family member to support a child up to the age of 14 years.

The problem with the grants is that they may issue short-term relief, but can also create possibilities for economic, social and sexual exploitation of children by adults (Dawes et al 2007).¹

Germann (2005)² relates all these support mechanisms to the development and sustainability of self-efficacy by children in a CHH, as it is important for self-esteem and improved quality of life for these children. Limitations in one social support may create a stressor in another.

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Conclusion

Contemporary literatures clearly pointed out those child-headed households appear to be a growing family constellation in Africa, in response to the unavailability of parents and other adult family members to care for children. We have seen in this chapter how HIV/AIDS and poverty are key factors in raising the vulnerability of children. These children carry a burden of family responsibilities and roles much greater than children in adult headed households. These responsibilities deprive children of time otherwise spent playing, socializing and studying. These children experience a range of emotional responses including depression, anger, anxiety and fear, all of which raise their psychosocial vulnerability. Many of these households are unable to generate sufficient economic resources to ensure their well-being. They are vulnerable to sexual exploitation, which frequently is related to their economic vulnerability. Similarly, food security and education often suffer as a result.

The capacity of children in child-headed households to resile should not be underestimated (Germann, 2006). The response of social support and social welfare systems should be capacitate and strengthen these families, respecting and cherishing their integrity and their right to exist.
Chapter Three: Research Methodology

3.1 The research setting
Addis Ababa is the capital city of the country and it is accountable for the federal government of Ethiopia. It has 10 sub-cities and 99 woreda administrations.
The poverty situation of the city is so immense and reflected by unemployment, poor housing, overcrowding, and congestion, under developed social and economic infrastructures, high cost of living, and unhealthy environmental conditions coupled with, HIV/AIDS complicates the lives of the city dwellers in general and orphan children in particular. The HIV/AIDS prevalence rate of the city among the adult population is 7.5 % (8.9% female and 6% male). In the capital it is estimated that about 156,577 people are living with HIV/AIDS and 112,647 children lost their parents due to HIV/AIDS (2007, HAPPCO).
Nifas Silk Lafto sub-city has a total population of 316,108 (148,892 male & 167,216 female). It is one of the largest Sub-Cities In terms of population and surface area (CSA, 2008). The Sub-City shares borders with Kirkos in the North, Akaki Kality in the South, and Kolfe Keranyo in the West directions. It had 12 Woredas. Majority of the extreme poor children and girls whom the research addressed were not known or registered by local administrations /woreda/.
Although there was lack of accurate data about the proportions of child-headed households at sub-city level and woreda level, the aforementioned facts draw the attention of Non-governmental organizations and currently 46 Ethiopian residents’ charity organizations (NGOs) are running child-focused projects in the sub-city.
Harmful traditional practices such as female genital mutilation (FGM), child labor and trafficking, and severe corporal punishment are also extensively practiced in this area (MoLSA, 1996). Child-headed households are more exposed to malpractices such as child labor and trafficking, and corporal punishment as they have no caring families who can protect them. As they are children who lost their parents, they have remained without a minimum standard care and support that their childhood requires (FHI, 2010). They are without shelter and care, access to education and health services, livelihood and protection, parental love and affection.
3.2 Study design

This study employed a mixed research design. In the qualitative assessment, in-depth interviews, focus group discussions (FGD) and key informant interviews were conducted. For the quantitative component, a cross-sectional survey that involved labor and social affair office, Nongovernmental organizations, teachers and school principals was employed. Besides, record analysis of school achievement of students was consulted to nearby schools of research setting.

3.3 Sampling Techniques and Selection of participants

Four Woreda Administrations (woreda 01, 3, 5 and 7) were randomly selected using a lottery method out of the total 12 Woredas. Pertinent stakeholders and organizations including NGOs, CBOs, FBOs, Schools and Government institutions such as women, children youth affair and labor and social affair offices were involved. Besides, sub-city MoWCYA and MoLSA took part and a total of 114 samples were drawn.
In locating child-headed households, it was highly dependent on people who knew the area well. Purposeful and Snow-ball techniques were crucial in escalating the number of child-headed households. Although the existence of child-headed households is sometimes denied by community members as well as local authorities, the role of community based and non-governmental organizations have remarkable exertion.

The participants in this study were first and foremost children living in child-headed households. In some cases neighbor or relatives of children were also interviewed. In addition, people working for CBOs, FBOs and NGOs in the area, and staff from the local office of Social Affairs, teachers and school principals, guardians and community volunteers were took part.

The first criterion in the selection of the participants was that the participants lived in a child headed household. As discussed earlier, childhood cannot be defined solely by age, and is largely socially constructed. Nonetheless, narrowing the working definition with age restrictions seemed the most viable solution to the criteria difficulties. By mainly focusing on children under the age of 18 living together, households with adult relatives (such as (grand) parents, aunts and uncles) were excluded. In-depth interviews were conducted with 10 purposefully selected 10+ years old orphans who are head of households and with 50 community volunteers who are currently serving orphan and vulnerable children.

Focus group discussions (FGD) were conducted among three groups of younger siblings who dwell in child-headed household (n= 30) [18 female & 12 male] to explore live experiences of child-headed household orphans.

Key informant interviews were conducted with a total of (n= 12) individuals representing; Community based organization (CBO), Faith based organization (FBO) and Sub-city/Woreda women, children and youth offices. Woreda child advocacy officers were purposefully selected for in-depth interview.

For the quantitative component, a cross-sectional survey that involved labor and social affair office, Nongovernmental organizations, teachers and school principals was employed. Semi-structured and structured questioners were administered to labor and social affair office, Nongovernmental organizations (NGO), Teachers and school principals (n= 12), four representatives from each actors. Besides, record analysis of school achievement of students was consulted to nearby schools of research setting.
### Table 2: Sample Woredas, Households and participants

<table>
<thead>
<tr>
<th>Woreda administration</th>
<th>Type of participants</th>
<th>Total number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Household headed children (CHH)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Younger siblings (FGD)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Volunteers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Key-informants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Survey participants</td>
<td></td>
</tr>
<tr>
<td>01</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>03</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>05</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>07</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>10</td>
<td>30</td>
</tr>
</tbody>
</table>

**Remark:**

- Community volunteers were selected purposefully based on their willingness and relevant work experiences.
3.4 Data collection procedure

Quantitative data was collected using questionnaires that were translated into Amharic. The questionnaire consisted of three parts for NGOs, Labor and social affair office representatives and teachers and school principals. The questionnaires were pilot tested. Depending on the obtained feedback the questionnaires were improved for final administration.

Qualitative data was collected using FGDs, KIIIs and in-depth interview in order to explore shared perceptions and lived experiences. Perceptions and experiences primarily related to role and responsibilities assumed by household headed children and orphans, children self-efficacy belief regarding household responsibility, factors affecting child-headed households’ efficacy including social capital/ reciprocity, role adjustment, coping and survival strategies.

Three FGDs were conducted with 30 orphans (younger siblings), comprising 8-12 orphans per group, Key informant interviews were conducted with a total of 12 individuals representing Ministry of Women, Children & Youth Affairs (MoWCYA) offices at sub-city and woreda levels, Community and faith based organizations.

For the quantitative component, a cross-sectional survey that involved labor and social affair office, Nongovernmental organizations, teachers and school principals was employed (n= 12), four representatives from each actors.

An interview schedule was compiled by the researcher. The interviews were face to face and each approximately 30-45 minutes in length. Open ended question was used in the interview so that participants were able to give comprehensive answers in their own words and more directive questions were used to clarify certain points. For the group of child heads, all the interviews took place in their homes and natural settings.
3.5 Data Analysis

**Quantitative Data:** The data collected through questionnaire were presented using graphs and frequency distribution tables. The results were interpreted using statistical measures such as percentiles, mean, and standard deviation.

**Qualitative Data:** The information collected through interviews and focused group discussion were transcribed and categorized into themes systematically and interpretation was made accordingly. Transcribed data were read and re-read to define themes and sub-themes and organized according to objectives of the study. A matrix was used to categorize and interpret the data.

3.6 Data Quality control

Whatever procedure for collecting data is selected, it should always be examined critically to assess the extent and what it is likely to be reliable and valid. Proper consideration had been taken in order to make the data collected to be valid and reliable. The researcher has taken three major steps to make the collected data valid and reliable. The first step was pilot testing the questionnaires and the interview guides.

The second measure was using different data collecting instruments; interviews, questionnaire, focus group discussion, record analysis and observation (triangulation of instruments) to collect data and as a third measure various respondents; Community based organization (CBO), orphan, community volunteers, social affair representatives and Non-governmental organization (triangulation of respondents).
3.7 Ethical consideration

There are four fundamental duties or responsibilities that the researcher has in this research: to seek individual informed consent, to protect participants from harm and increase possible benefits, to ensure that the benefits and burdens of research are distributed, and that information remains confidential. These principles apply in all research, but it is assumed that these are more complicated when doing research among children. These assumptions are largely based on the premise that children and adults are intrinsically different.

It is sometimes argued that children cannot give informed consent because they are not able to fully understand the content and consequences of participation. In addition, children are seen as more vulnerable and hence in need of protection. Children should be protected from harm caused by research (as should adults).

Proper permission was requested from the sub-city women, children and youth affair office. The office was introduced with the whole purpose of the study and area of expected cooperation. All key stakeholders who participated in this research were informed about the aim of the research and their consent was obtained. It was made clear to all respondents that the information they gave will remain confidential until the end of the study and all materials will get rid off at the end of the study. Researcher commitment with regard to informed consent, confidentiality and anonymity throughout the process were maintained.
Chapter four: Findings

Data were collected in January to March, 2015 from all research participants. A total of 114 participants were involved in the qualitative and quantitative survey. The survey was administered to 12 participants from child focused NGOs, Labor and social affair office and teachers and school principals. Three FGDs, 12 KIIs and 60 in-depth interview (involving a total of 10 household headed children & 50 community volunteers) were conducted with the target groups in the qualitative methods.

The findings of this research are presented in several sections. The first section provides the demographic details of each participant and their family constellation to give the reader a sense of their context. The remaining sections present the findings of the thematic analysis of the interview transcripts, focused group discussion and survey results.

The study gathers relevant data on major household roles and responsibilities assumed by children, perceived capability of household headed children, factors affecting efficacy of child-headed households and the role of various stakeholders for enhancing efficacy of child-headed households. All of the child household heads in this study were double orphans with age ranges from 13 to 17 and had no relative to take on the responsibility of caring for younger siblings. At the time of the study, the participating household headed-children of the study look after on average two siblings with age ranges from 5 to 15. With regard to the gender composition, the study gathered evidence from three households headed by boys and the remaining seven households by girls. The majorities of the children visited for this study live in decaying and depleted houses. These conditions expose the children to wind and rain.

One component of care and support service to child-headed households should be renovation of existing depleted houses of destitute households to protect children from exposure to various problems. This may be accomplished through mobilizing local resources from the community by the community.
4.1 Demographic Information of child-headed households

<table>
<thead>
<tr>
<th>Child-headed household</th>
<th>Gender of head</th>
<th>Grade</th>
<th>Age of head</th>
<th>Age of younger siblings</th>
<th>Number of siblings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M</td>
<td>3</td>
<td>15</td>
<td>5,7</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>5</td>
<td>14</td>
<td>9,11</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>M</td>
<td>7</td>
<td>16</td>
<td>8,14, 15</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>F</td>
<td>8</td>
<td>16yrs &amp; 11m</td>
<td>8,10, 12,15</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>6</td>
<td>13</td>
<td>7,11</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>2</td>
<td>15</td>
<td>6,11</td>
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<tr>
<td>7</td>
<td>F</td>
<td>3</td>
<td>16</td>
<td>10,12</td>
<td>2</td>
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<tr>
<td>8</td>
<td>F</td>
<td>4</td>
<td>15</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>M</td>
<td>College</td>
<td>17</td>
<td>9,12</td>
<td>2</td>
</tr>
<tr>
<td>10</td>
<td>F</td>
<td>2</td>
<td>14yrs &amp; 7m</td>
<td>6</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 3: Composition of Child-headed households

Table 2 shows the composition of the households, the ages of the head of the households and of siblings, the number of younger siblings and gender composition.

It should be noted that the oldest household member was the one who was identified by outsiders as the head of the household. The composition of households noticeably pointed out that Age is an important determinant for household headship.

Although a few households had been child-headed for less than a year, for most households it had been for longer than four years. The average duration that the households had been child-headed was five years.

When we see the educational levels and gender of household headed children, seven household heads are female and only three out of ten are males, the participant’s education status ranged from Grade 2 to college (Participant 9) but no one was completed Grade 12 or Preparatory.

Most female household heads were ranged from grade 2 to 8. According to in-depth interview findings, this is partly explained by household chores that female children assumed and the low probability of passing Grade 8 national examination due to poor class attendance and retention.

This finding made it clear that children survival duties overwhelmingly invade education and their future asset.
When housing condition of child-headed households was assessed, it was reported that in 4 (40%) of houses, water leaked into the part of the house where the children slept when it rained. The proportion of houses where wind blew into the part of the house where children slept when it is windy outside was 5 (50%). The proportion of Child-headed households who lived in an adequate shelter during research was found to be 1%.

### 4.2 Demographic details of Community volunteers

As detailed in Table 3 below, of the total respondent volunteers, 46 (92%) were female and 4 (8%) were male. One (2%) of the volunteers was found to be less than 18 years old while 43 (86%) were ranged from 25-45 years.

<table>
<thead>
<tr>
<th>Age group</th>
<th>Male No. (%)</th>
<th>Female No. (%)</th>
<th>Total No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;18</td>
<td>0</td>
<td>1 (2.1)</td>
<td>1 (2)</td>
</tr>
<tr>
<td>18-24</td>
<td>0</td>
<td>2 (4.3)</td>
<td>2 (4)</td>
</tr>
<tr>
<td>25-45</td>
<td>4 (100)</td>
<td>39 (84.7)</td>
<td>43 (86)</td>
</tr>
<tr>
<td>46-64</td>
<td>0</td>
<td>4 (8.7)</td>
<td>4 (8)</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>46</td>
<td>50</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Male No. (%)</th>
<th>Female No. (%)</th>
<th>Total No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>1 (25)</td>
<td>3 (6.5)</td>
<td>4 (8)</td>
</tr>
<tr>
<td>Married</td>
<td>3 (75)</td>
<td>40 (86.9)</td>
<td>43 (86)</td>
</tr>
<tr>
<td>Divorced</td>
<td>0</td>
<td>1 (2.1)</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Widowed</td>
<td>0</td>
<td>2 (4.3)</td>
<td>2 (4)</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>46</td>
<td>50</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Educational status</th>
<th>Male No. (%)</th>
<th>Female No. (%)</th>
<th>Total No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No formal education</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Primary (grade 1-8)</td>
<td>4 (100)</td>
<td>5 (10.8)</td>
<td>9 (18)</td>
</tr>
<tr>
<td>Secondary(grade 9-12)</td>
<td>0</td>
<td>41 (89.1)</td>
<td>41 (82)</td>
</tr>
<tr>
<td>Preparatory</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>46</td>
<td>50</td>
</tr>
</tbody>
</table>

### Knowledge about CHH
Approximately more than two thirds of the volunteers (86%) were married while 4% and 2% were widowed and divorced, respectively. When educational status of the volunteers was assessed, it was found that 18% of the community volunteers had achieved primary and 82% secondary level of education.

### Table 4: Socio-demographic characteristics of Community volunteers

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4 (100)</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td>46 (100)</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>46</td>
<td>50</td>
</tr>
</tbody>
</table>

### Figure 2: Community volunteer's source of knowledge about child-headed households

Regarding knowledge of community volunteers about child-headed households, it was found that 100% of volunteers had knowledge about child-headed households but the preferred term was ‘household governed by children’ or ‘children caring for children’ than child-headed households. As detailed in figure 4 below, knowledge of key stakeholders about Child-headed household was also assessed, 100% Teachers & school principals, NGO, MoWCYA and CBO participants said they knew about Child-headed households.

Qualitative data from participants in FBO and MoWCYA reveal the common assertion that ‘Child-headed households was meant to orphan & vulnerable children.’
Findings from woreda\(^3\) labor and social affair office revealed all research participants had never heard about child-headed households. All woreda labor and social affair offices were recently organized (not later than 6 months prior to the research).

![Figure 3: Respondents knowledge about Child-headed households](image)

Knowledge of key stakeholders about Child-headed household was not adequate given that most of them related child-headed households to orphans and vulnerable children. This shortage of apparent information has concealed the peculiar nature of their problems and the kinds of special support they need. Aid to child-headed households has been combined with support for orphans and vulnerable children. Hence, child-headed households remained unaddressed and denied their existence.

\[^3\) woreda (kebele) is the smallest administrative unit in Ethiopia\]
4.3 Demographic characteristics of Key-informant interviewee

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<th>Age group</th>
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**Table 5: Socio-demographic characteristics of Key-informants interviewee**

A total of 12 Key-informants were interviewed out of which 10 (83.3%) were male and 2 (16.6%) female. Of these, 10 (83.3%) were between the age of 25-45 and only 2 (16.6%) of respondents were above 46. Approximately 83.3% of Key-informants interviewee had first degree and only one (8.3%) participant had diploma. When years of experience in dealing with children were assessed, it was found that 8 (66.6%) have 4-6 years of experience while 3 (25%) have 1-3 years of experience.
### 4.4 Demographic characteristics of survey participants

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<td><strong>Total</strong></td>
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**Table 6: Socio-demographic characteristics of survey participants**

As detailed in Table 5 above, of the total respondents, 9 (75%) were male and 3 (25%) were female. All respondents were found between the ages of 25-45. When education status of the respondents was assessed, it was found that only 1 (8.3%) had Diploma while 11 (91.6%) had first degree. When years of experience in dealing with children were assessed, it was found that 8 (66.6%) have 4-6 years of experience while 3 (25%) and 1 (8.3%) have 1-3 and 7-10 years of experience respectively.
4.5 Findings by Research questions

4.5.1 What are major household roles and responsibilities assumed by child headship?

Living in a child-headed household is not necessarily the outcome of choice for many children. They may be forced to do so, they may not know relatives, or relatives or community-members may not be willing or able to foster them. In any case, death of or abandonment by (grand) parents are not matters of choice. Nevertheless, a certain amount of agency or exercising of power is expected from these children as they have to execute ‘adult tasks’. Because effective children in child-headed households first of all have to deal with running their households, aspects of role and responsibilities will be very useful in studying the efficacy of child-headed households and examining possible strategies of children.

Gender norms play a role in the identification of the heads in adult-headed households in Ethiopia. A husband who works elsewhere may be identified as the ‘head of the household’, while the wife makes major decisions concerning the daily running of the household and the care of children but this may not be true in child-headed households.

One key informant exemplified the situation of Child-headed households as follows:

“Identifying the head of the household and understandable role and responsibility in child-headed households is sometimes difficult especially if older girls are not there. Most household’s girls are found to do most of the household chores and make most decisions about the major daily operations.”

4.5.1.2 Adult-type of role and responsibility

Children heading the households will shoulder all the bulk of the housework which included cooking, cleaning the house and washing the clothes with little or maximum help from other members of the household. Many of the tasks that children in child-headed households may take on are considered normal for children. However, the time spent on these tasks and the extents of the responsibilities are assumed to be much greater.
One interview Child-head said the following:

“All people in neighborhood perceived as ‘older’ or more matured than our peers who lived in adult-headed households because we engaged with all rounded tasks regardless of sex and age.”

4.5.1.2.1 Earning an income
Apart from their roles, household headed children 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. Several children who were heading their households made the decisions for earning money and supporting younger siblings which affect schooling and result in frequent school dropout. Focused group discussion participant associated parental death to economic insecurity as follows:

“Losing a mother and father consequently means the loss of both income and care.”

Most child-heads and siblings were engaged with temporary jobs such as domestic work, conducting taxi, working in garage and shoe shine. The maximum income was 50 birr per week for garage and 20 to 30 birr per day for conducting taxi. The majority of orphans and female household-headed children were domestic workers who face multifaceted challenges. For example, one domestic worker told the researcher her own story as follows,

“My name is Abebech*. I am 14 and double orphan. I am a grade 2 student in the evening session at…….primary school. Serving as domestic worker has been challenging task for girls especially for orphans. Recently my employer left home to visit their family out of Addis. On one day when they were gone, her younger son came home late in the night and asked me to sleep and have sex with him. I was shocked and scared. My immediate response was to scream. I shouted at him and told him that I was not ready to do what he was asking. Something came to my mind. I buy time and look for an escape route. I cooled down, stopped shouting and moved toward him as though I had given in to what he needed. I pretended to be going towards the bedroom but made my way through another door out of the house. I went and knocked on my neighbor’s door and told them
what happened. They were so sympathetic and allowed me to spend the night in their house.”

Figure 5: Occupation of household-headed children's

As pointed out in figure 5 above, of the total 10 household-headed children, the majority of the child-heads earn their livelihood for their household through daily labor, petty trade, conducting taxi, garage and domestic work, so earn very little. A significant number of girls including students are engaged in domestic employment. A school principal explained the situation as follows:

“Some students were engaged in domestic work even at the age of 10-14.”

Child-headed households in urban areas are more vulnerable to exploitative circumstances than their rural counterparts. Life on the streets and the desperate need to make money on a daily basis aggravates the susceptibility of child-headed households and orphans to economic exploitation, hazardous work, forced labor and physical abuse.

*All the names used by researcher were pseudonyms*
4.5.1.2 Routine household chores

According to Ethiopian culture, children must be socialized into adult roles and responsibilities, and helping in and around the household is considered an important aspect of the upbringing of children. What distinguishes child-headed households is their involvement for a longer time, with larger responsibilities that cost education, schooling and future welfare at large.

In-depth interview participant explained that all children in child-headed households engage in routine household chores but with a greater involvement of girls than boys. Genet lost her mother and father four years ago and she was left alone to take care of her two younger siblings. She said:

“We do cooking and washing, we have to clean the house. There is no role division among us, but sometimes I do most of the things in the house because I am older.”

Child-headed household responsibilities are compulsory given that no adult members can take over their duties if they were too busy with schoolwork or any other reason. In-depth interviewee participant explained his situation as follows:

“My obligatory household responsibilities are totally absent or optional tasks for my friends in adult-headed households because they have a mother, a father, domestic worker and even grandparents.”

When child-headed households were in possession of money, the responsibility for keeping the money was on the hand of child-head but making decisions on how it should be spent was made collectively.

“Since our source of income was limited to conducting taxi and street trade, we are expected to share expenses wisely. While I was working for taxi, my friends smoke and chaw khat and they return home with empty pocket, but I am always curious about it because of my sister advice and support. At all times, I return home with enough money and bring food for my sister.” (FGD participant sibling)
“I become so happy while I was busy with household tasks because there were terrible times when we could not find something to cook and eat; I couldn’t even afford to buy bread for my brothers and sisters.” (Household head girl)

These children carry a burden of family responsibilities and roles much greater than children in adult headed households. These responsibilities deprive children of time otherwise spent playing, socialising and studying. These children experience a range of emotional responses including depression, anger, anxiety and fear, all of which raise their psychosocial vulnerability. Many of these households are unable to generate sufficient economic resources to ensure their well-being.

4.5.1.3 Parental-type of role and responsibility
4.5.1.3.1 Addressing orphans need for love and attention

“Hunger for love is much worse than hunger for nourishment.” (FGD, orphans)

Children in child-headed households need love and attention the most. Children in adult-headed households will be nurtured and protected by their parents or other relatives, while children in child headed households will most likely miss out on this.

“I believed that I wholeheartedly provide love, affection and maximum care for my younger siblings. My commitment to substitute our parents makes me worthy girl. However, I questioned my capability especially when there is no food in the house…..that is my real test.” (Household head girl)

“There has never been a mother like mine in building emotional belonging and family tied which has helped me to undergo sense of attachment and security. However, after her death my emotion was broken, i failed to accept the reality.” (FGD, orphan)

“I strongly feel worthless and lonely after the death of my mother who has brought tangible changes in my life through building my confidence and knowledge. Her lesson will always help me to make important decisions.” (Household headed boy)

From the accounts of the In-depth interviewee and FGD participants, a sense of belonging is related to getting attention, being protected, loved and cared for.
A sense of belonging does consequently not only involve the household to which a child belongs, but also the community and school settings at large.

Regarding the most worthy value that children inherited from their parents, significant number of household headed children and siblings reported that parents opt for open discussion, unconditional love and emotional stability were always in memory of children.

“When my mother was alive, we discuss dozen of topics without limitation, we talk all rounded issues. She was my mother, my father, my friend and my teacher. But after her death, I lost all once, I become lonely.” (Household headed girl)

Significant number of orphan girls have longstanding and positive attitude towards their mothers and feel uneasiness regarding the burden they shoulder to raise children. Surprisingly, some household headed children and orphans blame their deceased fathers for irresponsible behavior such as using drugs and consuming excessive alcohol which actually costs the life of principal income providers to HIV/AIDS.

4.5.1.3.2 Caring for ill siblings

For this particular study caring for sick adults is a much less common task for children but displaying parental behavior towards their siblings was more prevalent in the child-headed household. This study pointed out that orphans and non-orphans have unequal access to health care services, of those children who received medical treatment; the majority went to public health institutions, and a small percentage either to NGO health facilities or traditional healers.

These findings indicate that most child-headed households prefer to take their sick children to governmental health institutions which provide free health care to the poor and destitute. It is also interesting to note the continuing reliance on traditional healing, particularly in semi-urban area of the study setting. The research participants felt that child-headed households were still more likely to be denied healthcare than adult-headed households. This was seen to be due to lack of adequate care and financial constraints. One interviewed volunteer replies that:

“When children from child-headed households are sick most household heads don’t take them to clinics. Instead they give them medicine (tablets) at home. Only when the sickness
gets serious they would take them to clinic. There is a big difference between child-headed and adult-headed households regarding medical treatment.”

Data from the qualitative assessment suggested that diarrhea and fever are the most reportable disease among child-headed households.

“I have no prior experience on looking after sick children and i always associate illness with death because i lost my parents after long period of illness. Caring for ill siblings was additional burden.” (Household headed girl)

The in-depth interview participant noticeably depicted out that caring for ill children was more difficult than caring for ill adults especially when the caregiver was children.

“I always take Subsidiary actions for sick children. If he has fever, I will give him paracetamol and shower his face or head with wet cloth to lessen fever. If he has diarrhea, I will give him salty water to prevent dehydration, sometimes, the water worsens the situation because it may be contaminated or unsafe. It’s difficult to take sick children to get medication as soon as they feel unwell because we have no money at hand.” (Household headed girl)

Early traumatic events and lack of care and sensitive responsiveness by the community and government can harm the development of children leading to chronic vulnerability to stressful conditions. A healthy start in life greatly enhances a child’s later functioning in school, with peers, in intimate relations and with broader connections with society.

“After the death of my parent’s, I frequently experience depression, reduced self-esteem and self-confidence. Every morning I feel uneasiness and headache. Although I received treatment from nearby health center, I didn’t feel healthier because the nurse frequently prescribed low-priced drugs such as paracetamol or amoxicillin for all children who bring free medical letter from woreda health office.” (Sick orphan)
This study found that small number of orphan and vulnerable children have free medical letter that helps them to obtain free of charge treatment for common and uncomplicated infections in government health centers. However, Qualitative data has revealed that those children who bring free medical letter during treatment were labeled as “poor of the poor” and usually received low quality of treatment.

“I strongly feel the government should give due emphasis for quality of treatment and addressing more number of disadvantaged children that would brought tangible changes for health related stresses faced by child-headed households.” (Community volunteer)

“Generally health professionals have negative attitude to orphans, they are not comfortable to give enough time during examination and most of the time there is misunderstanding during examination, they are hectic with ridiculous and repeatable questions. Sometimes, they simply prescribe a drug without consulting sick orphans and this may probably cause poor health outcome after treatment.” (Sick orphan)

Psychosocial difficulties of child-headed households and orphans are compounded by feeling of abandonment and lack of responsive care. Some of the children in the study were inclined to generalization which aggravates children’s adjustment challenges.

4.5.1.3.3 Addressing orphans need for information and guidance

“I have to learn everything from the street.” (FGD, orphan)

Most children involved in the study indicated that lack of adult supervision and sense of detachment negatively influences their intention to seek advice and information. For adult headed households mothers were the primary source of information about sexual and reproductive health related issues but after the death of parents intimate friends and schools become important source of information.

“When I first saw menstruation, I was so desperate and disturbed because I have no prior experience and I never heard about it. I was not comfortable to share my experience and ask over advice from my school friends rather I missed one week class with annoyed state
but now I am ready to share my experience to girls without any hesitation.” (Household headed girl)

Beyond lack of prior experiences and preparedness for menstruation, adolescent girls have been faced problems access to sanitary products and miss significant numbers of learning days due to financial constraints to purchase sanitary pads which impedes their ability to compete in the classroom.

“Limited awareness about sexual and reproductive health related issues among child-headed households and orphans was frequently reported and becoming major concern. To this end, schools and NGOs should take the leading role for enhancing awareness among school & out of school youths to prevent HIV/AIDS, unwanted pregnancy and its consequences.” (Key informant, NGO)

HIV/AIDS and other reproductive health problems worsened a pre-existing strain that child-headed households had apparently faced. Moreover, in child-headed household’s adolescents assumed developmentally inappropriate adult responsibilities that affects Adolescent overall development.

“Lack of experience in decision making and seeking advice was significant impediment for child-headed households, especially girls must practice assertiveness to resist unwanted peer pressures, I personally witnessed how much missing a parent had exposed children for sexual and physical abuses.” (Household head girl)

The children’s emotional needs are suppose to be met within the family, but when there was no adult or significant others, the children encountered difficulties. In this study the social relationships and proximal interactions of the children in the child-headed household were not as strong and diverse as they should be, after the loss of their parents and being split to live with other families or dwell on street. Emotional and socio-economical supports in particular were repeatedly mentioned to have far reaching implications for child-headed households.
4.5.2 How do household headed children’s perceive their capability?

Despite what is currently known about the factors that result in children assuming the burden of household responsibilities, little information is known about the capability of household-headed children in running households in countries with high proportion of orphan and vulnerable children, such as Ethiopia. Hence, the plight of children in child-headed households presents difficult and vexing questions that require practical and realistic solutions.

When perceived capability of household headed children was assessed (Annex 1), most children positively evaluated their caring effort. Of the interviewed 10 household headed children, 4 were evaluated their capability very good and more girls (5) were able to evaluated their caring effort excellent. On the other hand, only 1 girl certainly asserted that she was poor in running her household. However, there was significant difference between boys and girls in relation to perception of household capability. Most girls emphasized the importance of physical and emotional presence of elderly siblings in child-headed households. On the contrary, boys signified the value of social support system and economic capability in addition to physical and emotional presence of matured siblings.

“To my knowledge, the essential constituent behind children capability is the ability to protect siblings from potential hazards and addressing basic biological and psychosocial needs such as emotional support, unconditional love and nutritional requirements equally for all siblings as if he/she is a father and mother.” (Household headed girl)

“Although assuming household responsibility is not trouble-free task for children, as far as government and community supports were availed, we can serve our siblings with utmost effort. Beyond care giving role, physical presence of older siblings has positive implication for orphans because lonely children are more prone for depression and anxiety disorder.” (Household headed boy)

Apart from the responsibility household head children have to care for younger siblings, an attempt to generate income and other inapt tasks highlights a number of other issues that children in this situation are faced with.
“Capability of household headed children is many-sided concern that draws the attention of multiple actors at large. The death of a father/mother may result in the loss of income and financial support as well as the degradation into poverty. Besides, loss of parents’ leads to the prolonged trauma resulted from psychological and emotional engagement of children.” (Key informant interview, CBO)

Such circumstances may also result in the child no longer attending school and withdrawing from other developmentally appropriate activities. A number of studies pointed out that schooling have positive impact on children self-reliance and capability for assuming household responsibilities. Consistent to the literatures, this research found that schooling was one major factor that influences capability of household heads, of the interviewed 10 household headed children, 9 of them evaluated their care giving effort very good and excellent, among these significant number of respondents where girls and on school children.

“After the death of my mother, I couldn’t concentrate at school, worrying about my future condition and wondering how I would stand against such realistic challenges, School is the only place that i feel alright, I enjoyed chatting with friends and talking freely all rounded issues, education is the only wealth that I inherited from my parents.” (Household headed girl)

Data from the qualitative assessment suggested that stigma and discrimination could influence the capability of household headed children significantly given that the experiences of children affected by HIV/AIDS may differ as a function of age, socio-economic background and, especially, by the type and nature of post-parental death placement and care.

“The cost of stigma and discrimination is not limited to psychosocial consequences but it also affects our confidence and capability. It is useful to note that we are not merely victim of social injustice.” (FGD, orphan)

Children experiences in the community as well as their dispositional factors both mediated and aggravated psychological adjustment and household capability. Although children interviewed in this study weren’t faced with expressed form of stigma and discrimination, significant number of
children especially double orphans were blamed and shunned by some community members. This study highlights the continuation of stigma in the form of victim blaming before, during and after the death of a parents.

“As a result of my parents’ death, some community members shunned and blamed me as if I was responsible for my parents’ death that affects my self-confidence and i didn’t even know that there are children who are living in desperate living condition in my neighbor.” (Household head boy)

Children are equally weighing the importance of neighborhood and extended family support to effectively deliver household roles. There is a need to focus on, in particular, the neighborhood special role for capacitating orphans and child-headed households in social and life skills including basic household tasks.

“From a socio-economic point of view, it seems there may be no differences between children from child-headed households and other children from the same communities where the general poverty levels are exceedingly high. However, orphans and child-headed households are above all facing devastating consequences of living and coping with parental illness, bereavement as well as carrying the responsibility for a household. Illness and bereavement-related effects include reversal of roles, living with parental illness, denial and fear of the impending reality, grief and sense of loss, and the apportioning of blame.” (Key informant interviewee, WCYA)

Beyond children natural tendency towards resilience and coping with stress, there were a number of opportunities acknowledged by children including extended family support and on time response from the community and NGOs.

“A community volunteer from nongovernmental organization has visited my home at least once a week and she advice me on how to care children and managing households. This opportunity helps me to look after siblings with skillful manner and her follow-up improve my capability. Now, I know what to do to address problems of children and how to address it.” (Household head girl)
An interview with households headed by children and orphans clearly suggested that good communication and harmony among siblings are important factors that affect the capability of children.

“The major capacity we have achieved through managing household is how to tolerate misunderstandings and communicate smoothly with siblings and thrive for effective adulthood.” (Household head boy)

“We usually respect and follow our older brother rules and regulations because we started from nothing and now we are all leading a successful life because of him.” (FGD, orphans)

In child-headed households, lacking adults to talk to them, teach them important life skills and offer a source of protection, many orphans and vulnerable children report feelings of loneliness and isolation. Similar opinions were reflected on the role of peer support to deal with the effects of isolation, marginalization, trauma and grief among child-headed households.

“Over the last year I have came across with isolation and feelings of loneliness which threatened my existence more than anything else. School was the only place that I feel better.” (FGD, Orphan)

Qualitative data has revealed that children reported to feel better at school. It seems that school serves as a source of relieve and social support.

“Beyond employing coping and survival strategies, children are expected to approach the extended families wisely and adhere to norms and values of the society with systematic manner.” (Household head boy)

It was also found that children discipline and strategies significantly influence utilization of social support systems including extended family support. The rewarding role of discipline as source caring and nurturing children was acknowledged by participants.
4.5.3 What are major contributing factors that affect efficacy of child-headed households?

As stated in the previous sections, capability of household headed children greatly influences the collective efficacy of child-headed households. When orphaned, children are left to fend for themselves, taking on the responsibilities of managing the household and younger siblings with minimal to no financial support. Such children often grow up deprived of emotional and material needs and the structures that give meaning to social and cultural life.

The major factors that affect the efficacy child-headed households were related to lack of preparation for assuming adult role. Children are pushed into adult roles and forced to assume greater responsibility in their families. This affects their education and had a negative impact on their physical and mental health. Their problems were aggravated by the stigma and discrimination they had to face in the community, in their school, etc. The details are presented below.

4.5.3.1 Role Adjustments

Almost all children said they were totally unprepared to assume responsibility as head of the family and they found it difficult to run the household.

‘Role adjustment all of a sudden’

“I am Birtukan, 15 years old girl and 2nd grade student in……primary school. I have two siblings. We lost our parents to HIV/AIDS six years before now. When this happen I was 9 years old and I have no prior experience on household responsibilities. However, after my mother bereavement was gone, people told me that I am the only responsible person for rearing younger siblings because I was older and more matured than others. I start praying to God to give me the courage and strength so that I can accomplish my parent’s obligation. To this end, I withdraw from schooling and start working as petty trader and other part time jobs such as washing cloths and baking enjera. Although it was very difficult to address the basic need of children, more or less I start accommodating routine household expenditure such as food. We received onetime School related aids from local NGOs including exercise book, pen, pencil and uniform. I understand that assuming
parental role was the most fascinating obligation when it comes timely. However, it was so disastrous role when it was assumed by children unexpectedly."

According to Birtukan, it is clear that assuming household responsibility is extremely exhausting physically, financially and psychologically. She was pushed into adult roles and forced to assume greater responsibility in her families unexpectedly.

“In most cases children had no prior exposure or preparation on household responsibilities; Most were forced into this responsibility after the death of their parent or grandparent out of the blue.” (Community Volunteer)

The child may come to know household roles only when uninhabited by the parents. Such children are totally unprepared and unable to cope with social stigma and loss of community support.

“In certain cases, we are expected to perform a father, a mother and even a friend role all in all.” (Household head boy)

The scope of responsibilities household-headed children assumed was enormous and demanding which requires progressive experiences and maturity. They were devoid of access and continued participation in education and preoccupied with caring orphans and generating income all time. Children are being faced problem of role adjustment before and especially after the death of parents. In accompanied child-headed households older and sick grandparent/parents play greater role in coaching and guiding children when compared with those adult less or unaccompanied child-headed households (the case of this research).

4.5.3.2 Food and Nutrition

Over 80% of child-headed households involved in the research reported that they have experienced a shortage of food in the past twelve months. When the food shortage was assessed by days, 30% (3) of the households did not have enough food to eat for 8-10 days, 35% for 13-16 days and 24.3% for twenty days or more in the one month period prior to the research. For extreme cases, 10.8% households reported that they did not have enough food throughout the
month. Significantly higher numbers of respondents (76%) reported having food shortage in the month preceding the research (Figure 5).

Figure 5: Proportion of Child-headed households with food shortage in one month period prior to the research

‘Education and Hunger’

“Children failing of hunger while attending school”

Eskedar lost her parents when she was ten years of age. Since she has no family or relatives to turn to, she started to live in the streets of Nifas silk woreda 8 alongside the ring road, a place commonly known as Yoseph Bridge. With the help of local NGOs and other community based organizations, she received temporary shelter and enrolled for alternative basic education in Lideta sub-city. Eskedar was always worried about her next meal. She frequently experiences dizziness and numbness but it was not explicitly recognized by others. She remember one misfortune moment and told the researcher as follows, “While I was in morning class, I lost my consciousness unexpectedly, the classroom teacher and students become troubled and poured water on my face again and again, after half an hour I regained my consciousness and I felt guilty. My teacher takes me out from the class and asked me about the problem, I honestly told him that I hadn’t eaten for two days. The teacher became cold and he questioned himself and the people
around him. To my knowledge, this was routine experience for disadvantaged children and I believed everyone has knowledge of our living circumstances including the Government but with all knowledge, we still haven’t received any help.”

Most of the household income is spent on food. Some children get the advantage of NGO intervention, whereby the NGO provides highly vulnerable children with food. This saves the household from facing long period of hunger. Similar opinions were reflected on the impact of starvation which affects children academic performance and endurance.

“We noticed those students who don’t eat enough food become passive and depressed in class. They were absentminded and daydreamers.” (School principal)

The extent of poverty in the study area is widespread, and many factors increase households’ economic vulnerability, including death, illness, a lack of assets, and little or no support from the government. Extended family networks play an important role in the care of orphans and vulnerable children, but many of these families live in extreme poverty. Qualitative data has revealed that government schools become the showground for socioeconomic challenges of vulnerable children. Participants from school stated that:

“It doesn’t take time to understand the devastating effect of hunger at school; government schools become exemplary for hidden urban starvation.” (School principal)

“Over the last years we have witnessed how much urban starvation becomes challenging for child-headed households and highly vulnerable children in general. Furthermore, school enrollment, attendance and achievements were greatly affected by children survival duties.” (Primary school teacher)

Reduced access to food explained by various forms, such as lack of proper and nutritious diet and insufficient daily meals at household level. Besides, school children were forced to attend school on an empty stomach and slept with starving state.
4.5.3.3 Schooling and Education

As revealed from the qualitative results, it was found that education and schooling plays a paramount importance in enhancing children household efficacy and act as source of social support. However, the numbers of children who have discontinued their education in order to take care of their siblings and earning income become increasing. Beyond enhancing psychosocial competence, school related activities are an important aspect of early childhood development.

‘Household responsibility, children education and their future life’

“Frehiwot and her little siblings were living in Nifas silk laphto sub city of Addis Ababa. She lost her parents when she was a little girl as a result she had to endure a tough upbringing. When she was a young girl she travelled from Nekemte to Addis Ababa in search of job and a better life. When she first came to Addis, Frehiwot worked as a domestic worker and then as a daily laborer in different places. While she was working as a daily laborer, she got a chance to attend Alternative Basic Education in lideta sub-city. While she attends alternative basic education, she proves to be hardworking student and household head. Frehiwot was consistently outperformed from the class and she’ll be in the fourth grade this year. Sadly, the school was closed due to budget constraints and students were referred to government schools. Unfortunately Frehiwot and other household-headed students were unable to join government schools a full-time base because they were expected to support younger siblings and other family members through income generating activities during out of school time. She said: Now, I left with two options, attending evening class by letting my children alone at night and covering all expenses including tuition fee and scholastic related expenses or dropout schooling. I think withdraw from schooling is better option because I never let myself worry about my kids every evening.”

While NGO providers are potentially extending educational opportunities to the marginalized, concern remains that children living in extreme poverty or suffering acute forms of vulnerability continue to be excluded. Moreover, it is explicitly clear that Alternative basic education have
significant contribution to reach primary school-aged children excluded from access to the conventional state (Government) education system.

School enrollment was not an end by itself for disadvantaged children. Sometimes schools may require active participation of parents in different school related development programs. Besides, qualitative findings revealed that disciplinary and absenteeism related issues oblige students to bring their family to school. Participants from school unanimously stated that:

“When school children exhibit bad behavior, frequent absenteeism and poor school performance, they will be asked to bring their family to school. Since children coming from child-headed household have no adult family member who stands for them, this is significant concern. When this happen the homeroom teacher will take the leading responsibility and provide practical guidance for misbehaved children.”

The role of homeroom teachers as a mediator will be helpful to address children’s adjustment challenges. Withdrawal from school and social support system negatively affect children coping and survival strategies. Survey participants from school clearly pointed out that enrollment, attendance, and retention have positive correlation for successful educational outcome.

“When child-headed households school enrollment, attendance and achievement was highly affected by absenteeism to work (domestic work, daily labor), poor communication among children and teachers, sanitation & mobility problems especially during menstruation period and behavior related problems such as drug and substance use.”

4.5.3.4 Extended family support

Although children ability to approach and utilize the social support system was one major determinant factor for efficacy of child-headed households, the positive responses from extended families and the community have also paramount importance.

“I have wonderful uncle who look after all my siblings on a regular basis, he care us akin to his own children. He is responsible to pay house rent and other household consumptions.” (Household headed girl)
“Always worried about maintaining our family ties because I promise my mother to do so.” (Household headed girl)

According to Almaz, child headed households are also expected to adhere promises and other sanctions of parents regardless of its utility to the children. In the face of this fact, some children with child-headed households are reluctant to go in line with parental obligation and prefer their own style of life.

“I remember my father was a lonely person throughout this life, when he was a young boy he travelled from Gojjam to Addis Ababa in search of job and married my mother. However, my mother was rich with extended families but I never seen anyone of them until her death. They denied her because she was poor and married poor person. How could we consider these self-centered collections as extended family?” (Household headed boy)

Parents’ positive image and benevolence prior to death have effect on the quality and quantity of supports children will receive from neighbors and extended family members. This was highlighted by the study participants as follows:

“You know, my mother was so generous and religious woman who enjoyed helping people especially the poor. People confer her unique name “Aba sitew” to mean that she was accustomed with helping people unconditionally. When she was sick, people all over the town visited her regularly even after her death we received incredible and comprehensive support. I am always worried about other disadvantaged children because without such support our fate will be living on street.”

Most children involved in the study indicated that depending on parents past history disadvantaged children maybe victim of social reciprocity. Besides, there was circumstance that children faces social exclusion. This circumstance was illustrated by the study participants as follows:
“After the death of my father & mother I was nothing. I didn’t have anything and was waiting for peaceful death but always worried about my siblings. Before his death my father was woreda manager, his position requires working with different people and I understand that most outskirts farmers and urban residents develop negative attitude to him because they believed that he passed unwise decisions and give their land & house to investors in the name of development. Consequently, the community rejects his family and we face intolerable challenge until non-governmental organizations give me the opportunity to get loan through revolving fund and am now in good shape supporting my siblings with basic needs”. (Household headed girl)

On top of this fact, however, family past history was not considered as an end by itself. Children involved in the study also signify the role of coping strategies and resilience. Children ability to go in line with social norms and acceptable standards was found to be important source of social support.

“You know, we people specially children are not self-sufficient, we are created to be social animals, we must support each other. After the death of my beloved mother, I feel incompleteness and I absolutely accept the notion of belongingness because without external support I wouldn’t realize my dream. Many people call me “oldie” because apart from my education, I was engaged with multiple roles such as supporting my neighborhoods, daily labor and garage work. I was free from any drugs and addiction; this is the way to my brightest future...” (Household head boy)

Even if there are a number of indications that the extended family will in future be unable to continue absorbing orphaned and vulnerable children, traditional family and community structures in Ethiopia has positive trends in supporting disadvantaged children. Qualitative data clearly pointed out that Extended family supports play a vital role in preventing family disintegration among child-headed households.

“My name is Yeshaw. I am 17 years old boy and college student. I have two siblings. I lost my mother and father before 2 years ago. Like any other children, I used to assist my siblings through different kinds of part time jobs including carrying water, shoe shine
and working for garage. This has been negatively affecting my educational performance and personal hygiene. I had been frequently late for school, no adequate time for study at home and mostly wear unclean dresses. After the death of my father, his nephew and older brother frequently visited our home and bring food and provide financial support which enables our household to be sufficient when compared with other disadvantaged children. The support enables me to attend my education and partake with my friends freely with equal status. Hence, I would like to ask other extended families to provide support for all children in need.”

4.5.3.5 Emotional and social distress

Another important determinant of efficacy is the fear, uncertainty and behavioral changes in children associated with parental illness, death and bereavement. Qualitative data suggests that the above factors may lead to a decline in socio-economic status in affected households which will create additional psychosocial difficulties in the form of emotional and social distress.

“Fear of abandonment and repeated exposure to parental illness and death jeopardize orphans emotional and social adjustment. So far they received very little supports from the community and the government. Social support is the base for future wellbeing of children.” (Key-informant, CBO)

Parental bereavement from HIV/AIDS has a number of socio-economic and psychological consequences on child-headed households. The social and emotional supports during and after bereavement have enormous impact on children adjustment and sense of attachment. This was underscored by a key informant as:

“There are a number of indications that Children multifaceted household responsibilities were aggravatated by the devastating consequence of bereavement process and childhood despair.” (Key-informant, WCYA)

Negative bereavement outcome manifests in various forms, such as hopelessness and lack of trust. Children are exposed for extended period of grief and pessimistic thought.
Bereavement support helps grieving child to withstand troubles without complicated effect. To this end, dependable social support will be the only way-out for all disadvantaged children.

4.5.3.6 Economic difficulties

As we already seen in the previous sections, household headed children not only take on major household chores, like cooking, washing and decision making but strive to earn a substantial income which can enable them to manage their household expenses. Almost all research participants were engaged with part-time and lower payment jobs such as conducting taxi, shoe shine, garage and domestic works. Their monthly income ranges from 200 to 400 Birr per month. Evidently, children income is not enough to carry on household needs and most siblings and household heads were deprived from balanced and adequate food.

“How the death of my parents, I put on torn out cloths and eat once a day. There are, however, situations that eating once a day becomes difficult, now a day’s eating three times a day is only for well-to-do families.” (FGD, siblings)

Participants were asked whether they had some food reserve or store to cope up with an unexpected situation of loss of income or resources for food purchase. All child-headed households said they had no food reserve.

“Apart from food insufficiency, we are facing tangible difficulties such as frequent illness and financial limitations to access medical services, living in dirt house exposed for wind and rain, girls are prone for sexual and physical abuse which further elongates the circle of impediments. In general, Life in child headed household is always difficult.” (Household head boy)

“We have received very little support from the government although everyone knows that we are living in desperate living condition, we are poor of the poor in terms of economy and basic household consumption. Few NGOs provide support but the support is insufficient especially the food distribution is not adequate.” (Household headed children)
As stated on qualitative data, over half of the children are affected by some illness. Children complain of stomach problems in the form of diarrhea and vomiting, headaches and prolonged weakness. Poor quality of drinking water and lack of access to personal hygiene facilities greatly risks children health.

4.5.4. What are the roles of key stakeholders in the provision of care and support for enhancing efficacy of child-headed households?

Coordination of care and support through established mechanisms and standards to engage government bodies, CBOs, communities and the private sectors in order to enhance efficacy of Child-headed households will be fundamental issue. In as much as coordination of care is critical component for child-headed households, there were gaps that were identified by the different categories of participants.

4.5.4.1 The role of women, children and youth affair office (WCYA)

Although the role of sub-city and woreda women children and youth affair office seems significant for addressing disadvantaged children at grassroots level, it was found that WCYA has no a well-defined method of collecting, managing and reporting information about child-headed households situations and services. Research participants clearly pointed out that WCYA has no well documented evidence about child-headed households at woreda or sub-city level. In support of this argument, it was found that role of women children and youth affair office was limited to facilitation roles, recruitment and placement of children to NGOs, random eligibility assessments and service delivery follow-up.

“The role of woreda women, children and youth affair office in relation to children is to identify poor households with vulnerable children based on specific criterion and determine level of poverty, prioritize children that should get support, initiate working relationship with different sectors to support child-headed households and link them with different NGOs to get relevant support.” (Key-informant, WCYA)

Participants argued that WCYA has obligation to identify truly child-headed households who are in need of care and support from local government and private institutions and community members including Iddirs, religious organizations and individual community members to improve care and support for child-headed households.
“Woreda women, children and youth affair office must give due-emphasis for child-headed households.” (Community volunteer)

“Since documentation was the starting point for any evidence based intervention, all woreda and sub-city women children and youth affair offices should carry out grass root assessment of eligible children.” (Community volunteer)

Coordination of care for child-headed households and vulnerable children is an important component that helps to address more children in need and help stakeholders to work together for common goal. Yet, there is lack of clarity on how to ensure accountability of the parties involved.

“We witnessed that some woreda women, children and youth affair office play negative roles such as subjective recruitment of beneficiaries and lack of accountability and responsibility.” (In-depth interviewee, CBO)

“Most stakeholders including women children and youth affair office leave the issue of disadvantaged children for NGOs and Community volunteers.” (Community volunteer)

Data from qualitative methods shows that women children and youth affair office was the most important government body at woreda level for coordinating various supports and services for needy children. However, the quality of services given for children was questioned by respondents.

“Woreda and sub-city women children and youth affair office must carry out vulnerability assessment during recruitment of beneficiaries. Child headed households should received unconditional and genuine support.” (Key-informant, CBO)

Beyond different supports, vulnerable children need to be protected from various forms of exploitation and abuse.

“We noticed that some guardians or parents are not genuine parents. They force children to travel from rural areas to Addis Ababa and abuse them ( economical, sexual and
labor). Children have zero trust on them. Women children and youth affair office and other government bodies must act proactively.” (Community volunteer)

4.5.4.2 The role of Community volunteers

Community volunteers are members of the community who are identified by disadvantaged children. Most of them are provided with relevant trainings and are responsible for supporting children and their families. They are the front line in implementation of child focused Programs.

“*I spent time with child-headed households during holy day and I always give due emphasis for child-headed households.*” (Community volunteer)

Apart from spending time with Child headed households during holy day, volunteers are also provide food and psychosocial support for children. Besides, research participants clearly depicted that educational, moral and disciple related supports were given for needy children.

“*During home based visit, I bring food, cloth and provide psychosocial support.*” (Community volunteer)

“We follow and help disadvantaged children to attend their school, guide them on how to use time to study and equip them with moral and discipline. We also help them to keep their environment clean, on housekeeping and environmental sanitation. We visit every child-headed household twice a week.” (Community Volunteer)

Furthermore, CVs are provided with various trainings that they, in turn, share with children and guardians. The following case story clearly identified multiple roles played by volunteers.

“*What if these children are my own?*”

*Membere has been serving as a volunteer caregiver for the last three years in highly vulnerable children project which is being implemented in Nifas silk Lafto sub city. While she is visiting children and their families under her care, she pays attention to child-headed households and about the socio-economic problems that they have been facing. She regularly perform home based visit and bring food and personal hygiene materials for the children. She always said “what if these children are my own”.*
Part of her routine activity, she planned to support these children and their families through resource mobilization. Accordingly; she identified people who can support these children either financially or materially and made continuous discussion with 5 individuals who finally agreed to contribute Br 500 on monthly bases. Subsequently, the children are able to fulfill their basic needs and become very happy.

Beside resource mobilization, Volunteer caregivers are also responsible for indentifying vulnerable children and child headed households for placement with different support organizations.

4.5.4.3 The role of community based organizations (CBO)

When knowledge of the CBOs about child-headed households was assessed, 100% said they knew about child-headed households. Major source of knowledge includes, Report from community volunteers, Home based visit or surveillance and when there is complain from the community regarding orphan and vulnerable children. Most key-informant interview participant’s associated child-headed households with slum areas for the reason that nearly all residents of child headed households live in decaying plastic houses (see annex) where children are exposed to rain and wind, there is no safe water supply and latrine, they are prone to pests and insects and most of the time children are sleep on the ground.

Comparatively CBOs has been able to effectively identify child-headed households and work with community structures and local resources. Capacity of the community based organizations to care for child-headed households were developed through resource mobilization. Local resource mobilization was the primary source of income for CBOs. Resources mobilized from within the community have helped CBOs to provide educational materials, construction and renovation of depleted houses.

“Often resources mobilized from community level fill urgent gaps in addressing the needs of Disadvantaged children.” (Member of CBO)
Similar opinions were reflected on the role of CBO which coordinates disadvantaged children care and support at community level by mobilizing community resources and sustaining initiative activities.

“The CBOs monitors and supervises distribution and utilization of support provided to child-headed households and their families, supervise community volunteers and strengthen community-based child care and support initiatives.” (Key-informant, CBO)

Another important activity that the CBOs undertaken in order to achieve its objective was strengthening community coalition through arbitration to meet the need of disadvantaged children at all levels.

“Sometimes we act as a go-between for orphan and vulnerable children and the community.” (Key-informant, CBO)

4.5.4.4 The role of faith based organizations (FBO)

Evidence on whether a member of child-headed household received spiritual or emotional support from spiritual leaders shows that none of the households had received any of the services.

“Despite the fact that the number of household headed children are now increasing, Community support was not as much as expected. Psychosocial and spiritual issues need to be addressed.” (Key-informant, FBO)

“Since child-headed households were devoid of adult supervision, the role of spiritual and psychological support will have paramount role in preventing psychosocial crisis. In addition to material support, all rounded services such as spiritual counseling must be considered.” (Key-informant, FBO)

Qualitative data shows that faith based organizations provide school tuition fee and other scholastic supports for orphan and vulnerable children but the role of individual members (priests) was not clear or minimal.
4.5.4.5 The role of Nongovernmental organizations (NGOs)

NGOs play a variety of roles in supporting child-headed households including education service delivery. Some NGOs are primarily involved in parenting skill training for household headed children and food and nutritional support provisions.

“Parenting skills are essential for Household heads to enable them to provide quality care for their siblings. There were efforts by the program to provide child-headed households with this skill through parenting skill trainings.” (Key-informant, NGO)

Furthermore, shelter and care, legal protection, health care and psychosocial supports were given for disadvantaged children through nongovernmental organizations. Qualitative data revealed that the level of inter-sectoral collaboration among key stakeholders greatly affects implementations of child related programs.

“Meeting child headed households immediate needs is vital not only to their current well-being but also to their future. Our organization provides different supports including food/nutrition, shelter and care, legal protection, health care, psychosocial support and education. The completion of these activities would not have been possible without the assistance and support from the government.” (Key-informant, NGO)

NGOs are also provided community volunteers with relevant trainings as pointed out above and are responsible for looking after highly vulnerable children.

“We train older orphans (household heads) on parenting, sanitation, and how to track problems children encountered in relation to their education and health. We bring this to the attention of NGOs to solve their problems. Our role is to bring change on the outlook of the community towards vulnerable children. We checked out the child’s needs and problems.” (Trained Community volunteer)

Qualitative findings show that some NGOs are also engaged with economic strengthening activities and facilitating vocational training for guardians and older orphans who turn 18 years of age.
“Although most disadvantaged children have received various supports in terms of school materials, life skill training and tutorial supports, they were peripheral to economic strengthening activities because most of them are under 18 years of age and have no adult family member.” (Staff member of NGO)

Sometimes there is a contradiction in terms of children interest and NGOs programs concerning income generating activities. Most NGOs agendas are focused on the provision of educational related support for school children. However, there were situations that children who are under 18 will be benefited from income generating activities to support their family.

“When we plan child focused activities, we are guided by Ministry of women, children and youth affairs implementation guideline that encompasses seven service components including educational and economic strengthening activities, in the first case due emphasis was given for under 18 and school children whereas economic strengthening activities were primarily targeted out of school children and guardians.” (Program coordinator, NGO)

Before the new civil society organization proclamation ratification, one major intervention area of NGOs was human rights campaign and advocacy aimed at putting pressure on governments to fulfill their commitment to Education and other supports for disadvantaged children. However, after enactment of the law most NGOs were not in a position to enforce the Government regarding child related issues.
4.5.4.6 The role of school settings

Schools have become one of the most important settings where preventive and wellness promotion interventions for orphan children are conducted. This is due in part to the convenience of conducting interventions in a setting where the target population spends the majority of its time. It also reflects the fact that in addition to their central role of fostering academic development, school serves an important role in the health and socio-motional development of orphans.

Participants clearly suggested that spiritual disturbances, trauma, bereavement, stigma and discrimination either prevented orphans and vulnerable children from attending school or limited their performance in the classroom.

“Much of the gap between the schooling of orphans and non-orphans is explained not only by the greater likelihood that orphans will live with more distant relatives or unrelated caregivers but also lack of care and support being given by family members, primary school teachers and community members at large.” (Primary school principal)

“It’s true that more than a quarter of students coming from child-headed household’s school attendance and performance had deteriorated partly because of interruptions, and partly because of stress and unreasonable household responsibilities.” (Primary school teacher)

However, finding from school revealed that some orphan students were seen to be performing in school better than non orphans. Primary school teacher explained the situation as follow;

“I observed that some orphans were performing better than non-orphans. This was partly explained by tutorial supports that enable needy children to catch-up with their academic performance. Besides, there were coaching and help with homework when the child did not understand something and when there is frequent absenteeism that was provided by teachers and these supports were also found to be useful for orphans.”
Qualitative data from school revealed that performance of orphans was affected by frequent absenteeism to work and physical exhaustion after work.

“Orphans usually ask withdrawal from the schools for the reason that they are unable to afford even for food, let alone school fee and related costs while they are learning at evening division. They engaged themselves for longer hours in day in some jobs to help themselves and they become tired to attend classes regularly and properly which may lead to drop out of school. Teachers and school principals have the obligation to assist orphans with utmost effort.” (Primary school teacher)

Research participants underscore the need for quality of education and safe school environment for better educational outcome.

“The government must take the lead to ensure and facilitate safe school environment, provide support for disadvantaged children and guarantee quality of education.” (Primary school principal)
Chapter five: Discussion, Conclusions and Recommendations

5.1 What are major household roles and responsibilities assumed by child headship?

Children heading the households will shoulder all the bulk of the housework which included routine household chores, earning income, making decision and provide love and attention for siblings with little or maximum help from other members of the household. Many of the tasks that children in child-headed households may take on are considered normal for children. However, the time spent on these tasks and the extents of the responsibilities are assumed to be much greater. Furthermore, children are in general also expected to help with the care of younger siblings. The study revealed that gender norms play greater role on children household responsibility as most household’s girls were found to do most of the household chores and make most decisions about the major daily operations.

Consistent with Mika et al., (1987) category of household responsibilities, it was found that household head children’s assumed different types of roles and responsibilities including adult role such as earning an income, executing household chores; making dinner, cleaning the house and washing. However, these obligatory household responsibilities are totally absent or optional tasks for adult headed household children. Most child-heads and siblings were engaged with temporary jobs such as domestic work, conducting taxi, garage work and shoe shine, earn very little to support the households. Beyond earning an income and executing household chores, household head children’s were expected to respond younger siblings need for love and attention which is related to getting attention, being protected, loved and cared for, and being taken seriously.

Most children involved in the study indicated that lack of adult supervision and sense of detachment negatively influences their intention to seek advice. Girls reported that in the past mothers were the primary source of information about reproductive health and sexual related issues but after the death of parent’s intimate friends and schools become important source of information. Participant also depicted that lack of experience in decision making and seeking advice was significant impediment for child-headed households especially for girls. HIV/AIDS and other reproductive health problems worsened a pre-existing strain that child-headed households had apparently faced.
The children’s emotional needs are supposed to be met within the family, but when there was no adult or significant others, the children encountered difficulties. The family influences all aspects of the child’s development through input and behavior related feedback within it. In this study the social relationships and proximal interactions of the children in the child-headed household were not as strong and diverse as they should be, after the loss their parents and being split to live with other families or dwell on street. Emotional and psychological supports in particular were repeatedly mentioned to have far reaching implications for child-headed households.

Parental role was particularly related to caring for an ill parent, as the children who eventually headed the households were often the predominant caregivers as their parents became more ill and more dependent. For this particular study caring for sick adults, however, is a much less common task for children but displaying parental behavior towards siblings was more prevalent in the child-headed household. This study pointed out that orphans and non-orphans have unequal access to health care services, of those children who received medical treatment; the majority went to public health institutions, and a small percentage either to NGO health facilities or traditional healers. These findings indicate that most child-headed households prefer to take their sick children to governmental health institutions which provide free health care to the poor and destitute. It is also interesting to note the continuing reliance on traditional healing, particularly in semi-urban area of the study setting. The focus group discussions and key informant interview participants felt that child-headed households were still more likely to be denied healthcare than adult-headed households. This was seen to be due to lack of adequate care and financial constraints. Data from the qualitative assessment suggested that diarrhea and fever are the most reportable disease among child-headed households and children also argued that caring for ill siblings was more difficult than caring for ailing adults. This study also found that small number of orphan and vulnerable children have free medical letter/certificate that helps them to obtain free of charge treatment for common and uncomplicated infections in government health centers. However, Qualitative data has revealed that those children who bring free medical letter during treatment were labeled as “poor of the poor” and usually received low quality of treatment.

An added distinction (Winton, 2003) has been made between instrumental and expressive parentification. In instrumental parentification, a child is involved in practical tasks, such as
cooking, cleaning, and physical cares of those he or she parents, and sometimes earning an income. In expressive parentification, which is seen to be more threatening to a child’s well being, a child is attuned to the emotional needs of whomever he or she is caring for, and will provide emotional support, or be a peacemaker or mediator as required (Jurkovic, Jessee, & Goglia, 1991). Consistent with these distinctions, it was found that household headed children present with both instrumental and expressive parentification, by assisting with the household tasks and earning money for the household, as well as providing emotional support for household members.

5.2 How do household headed children’s perceive their capability?
Despite what is currently known about the factors that result in children assuming the burden of household responsibilities, little information is known about the capability of household-headed children.

When perceived capability of household headed children was assessed most children positively evaluated their caring effort. However, there was significant difference between boys and girls in relation to perception of household capability. Most girls emphasized the importance of physical and emotional presence of elderly siblings in child-headed households. According to them, age of child head was important determinant factor for household capability. On the contrary, boys signified the value of social support system and economic capability in addition to physical and emotional presence of matured siblings.

Apart from the responsibility household head children have to care for younger siblings, an attempt to generate income and other inapt tasks highlights a number of other issues that children in this situation are faced with. Participants revealed that Capability of household headed children is many-sided concern that draws the attention of multiple actors at large. The death of a father may result in the loss of income and financial support as well as the degradation into poverty. Besides, loss of parents leads to the prolonged trauma resulting from psychological and emotional engagement of children. Such circumstances may also result in the child no longer attending school and withdrawing from other developmentally appropriate activities. A number of studies pointed out that schooling have positive impact on children self-reliance and capability
for assuming household responsibilities (UNICEF, 2004). Consistent to the literatures, this research found that schooling was one major factor that influences capability of household heads.

According to children the ability to protect siblings from potential hazards and addressing basic biological and psychosocial needs such as emotional support, unconditional love were the essential constituent behind children capability. This study found that although household role and responsibilities are not trouble-free task for children, as far as government and community supports were availed children capability in caring for siblings will be enhanced.

Children experiences in the community as well as their dispositional factors both mediated and aggravated psychological adjustment and household capability. Although children interviewed in this study weren’t faced with expressed form of stigma and discrimination, significant number of children especially double orphans were blamed and shunned by some community members. This study highlights the continuation of stigma in the form of victim blaming before, during and after the death of a parents.

Data from the qualitative assessment also suggested that, stigma and discrimination could influence the capability of household head children significantly given that the experiences of children affected by HIV/AIDS may differ as a function of age, socio-economic background and, especially, by the type and nature of post-parental death placement and care. Accordingly, Children were equally weighed the importance of neighborhood and extended family support to effectively deliver household roles.

There is a need to focus on, in particular, the neighborhood special role for capacitating orphans and child-headed households in social and life skills including basic household skills. In child-headed households, lacking adults to talk to them, teach them important life skills and offer a source of protection, many orphans and vulnerable children report feelings of loneliness and isolation. Similar opinions were reflected on the role of peer support to deal with the effects of isolation, marginalization, trauma and grief among child-headed households.

An interview with households headed children and orphans clearly suggest that good communication and harmony among siblings were important factors that affect capability of children. It was also found that children discipline and coping strategies significantly influence utilization of social support systems including extended family support. The rewarding role of
discipline as source caring and nurturing children was acknowledged by participants. The findings from the study highlight the devastating consequences of living and coping with multiple losses as well as carrying the responsibility for a household. To this end, children capability of running households is imperative inquest to comeback with solution across multifaceted challenges faced by child-headed household.

5.3 What are major contributing factors that affect efficacy of child-headed households?

The major factors that affect the efficacy child-headed households were related to lack of preparation for assuming adult role, poor social support system, social reciprocity and socioeconomic difficulty. Children are pushed into adult roles and forced to assume greater responsibility in their families. This affected their education and had a negative impact on their physical and mental health. Their problems were aggravated by the stigma and discrimination they had to face in the community, in their workplace.

5.3.1 Role Adjustments

Following the death of their parents, children must make the adjustment from being a child to being the head of a household, an adjustment that carries many challenges. Nkomo’s (2006) study in Gauteng and Kwazulu-Natal identified several key components of this adjustment, including the feeling of having lost one’s childhood and sense of self with the attendant feelings of deprivation; of responsibility towards one’s family (younger siblings) and the obligation to take the place of the deceased parents; of being abandoned by extended family members who they feel should be taking responsibility for them; of concern for surviving in the face of economic hardship; of grappling with multiple and competing responsibilities; and of helplessness and uncertainty about personal safety, family disintegration and discipline.

Research participants meaningfully stated that in most cases they had no prior exposure or preparation on household responsibilities; Most were forced into this responsibility after the death of their parent or grandparent out of the blue. Child heads are expected to perform a father, a mother and even a friend role all in all but they come to know these household roles only when uninhabited by the parents. Such children are totally unprepared and unable to cope with social stigma and loss of community support.
5.3.2 Emotional /Social Distress

Another important determinant of efficacy is the fear, uncertainty and behavioral changes in children associated with parental illness, death and bereavement. Qualitative data suggests that Fear of abandonment and repeated exposure to parental illness and death jeopardize orphans emotional and social adjustment. Parental bereavement from HIV/AIDS has a number of socio-economic and psychological consequences on child-headed households. The social and emotional supports during and after bereavement have enormous impact on children adjustment and sense of security. There are a number of indications that Children multifaceted household responsibilities was aggravated by the devastating consequence of bereavement process and childhood despair. To this end, culture of bereavement support should be enhanced since it helps grieving child to withstand troubles without complicated effect. Dependable social support will be the only way-out for all disadvantaged children.

5.3.3 Food and Nutrition

More than 80% of child-headed households involved in the research reported that they have experienced a shortage of food in the past twelve months and most of the household income is spent on food. Some children get the advantage of NGO intervention, whereby the NGO provides highly vulnerable children with food. This saves the household from facing long period of hunger. The extent of poverty in the study area is widespread, and many factors increase households’ economic vulnerability, including death, illness, a lack of assets, and little or no support from the government. Extended family networks play an important role in the care of orphans and vulnerable children, but many of these families live in extreme poverty. Qualitative data has revealed that schools become the showground for socioeconomic challenge of vulnerable children.

After the death of parents, children are forced to put on worn-out clothing and eat once a day. However, there were situations that eating once a day becomes difficult, children were adopted the belief that ‘eating three times a day is only for well-to-do families’ because it was a dream but not a right for disadvantaged children in Ethiopia context. Reduced access to food explained by various forms, such as lack of proper and nutritious diet and insufficient daily meals at household level. Besides, school children were obligated to attend
school with empty stomach and slept with starving state. It’s important to note that urban starvation become challenging for child-headed households and highly vulnerable children in general. Furthermore, school enrollment, attendance and achievements were greatly affected by children survival duties.

5.3.4 Schooling and Education

Beyond enhancing psychosocial competence, school related activities are an important aspect of early childhood development. However, findings revealed that the numbers of children who have discontinued their education in order to take care of their siblings and earning income become increasing. While NGO providers are potentially extending educational opportunities to the marginalized, concern remains that children living in extreme poverty or suffering acute forms of vulnerability continue to be excluded. Moreover, it is explicitly clear that Alternative basic education have significant contribution to reach primary school-aged children excluded from access to the conventional state education system.

School enrollment was not an end by itself for disadvantaged children. Sometimes schools may require active participation of parents in different school related development programs. Besides, qualitative findings revealed that disciplinary and absenteeism related issues oblige students to bring their family to school. Since children coming from child-headed household may not have adult family member who stands for them, this is significant concern. The homeroom teacher will be expected to take the leading responsibility and provide practical guidance for supporting orphan and vulnerable children. The role of homeroom teachers as a mediator will be helpful to address children’s adjustment challenges and Cognitive developments. Withdrawal from school and social support system notably aggravated children coping and survival strategies. Schooling can act as buffer against the development of child delinquency and enhancing successful adulthood period by breaking circle of poverty. Survey participants from school clearly pointed out that enrollment, attendance, and retention have positive correlation for successful educational outcome.
5.3.4.1 The role of Alternative basic education for disadvantaged children

NGOs play a variety of roles in supporting education service delivery. Some NGOs are primarily involved in advocacy aimed at putting pressure on governments to fulfill their commitment to Education for All (Mundy and Murphy 2001). However, in Ethiopia, after the enactment of new charity organization proclamation, NGOs were not in a position to enforce the government regarding child related issues and prohibited from advocacy related activities.

Others are involved directly in education provision, primarily with the aim of providing educational opportunities to those children excluded from government schooling. Educational exclusion that such provision intends to address can take many multidimensional forms. It is often associated with being ‘hard-to reach’ in terms of where children live as well as who they are. Street children, orphans, child-headed households, religious and language minority groups, the disabled, refugees, and child laborers are often amongst those identified as being most excluded from government provision (Sayed and Soudien 2003; UNESCO 2004). These children are amongst those targeted by NGO education providers. In Ethiopia orphan and vulnerable children, child-headed households, children with disability, child laborers, victims of sexual abuse and street children are the key target group for alternative basic education.

International agency and NGO reports often suggest that students in NGO schools receive a better quality education compared with their counterparts in government schools, and that such provision is more cost-effective. However, one area that has been neglected in terms of understanding the benefits of these programmes relates to their impact on livelihood outcomes. Little is known about how access to NGO provision affects access to higher levels of education, or how it influences employment opportunities. (Pauline Rose Vol. 39, No. 2, P.221)

In order to reach the excluded, NGO provision is often viewed as aiming to develop an ‘alternative’ approach to education from the formal ‘conventional’ state system. Their approach started from the premise that ‘education can no longer be seen as a time-bound, place-bound process confined to schools and measured by years of exposure’, and so equated education with learning, regardless of where, how or when learning occurs (Coombs and Ahmed, 1974, 8).

The first Ethiopian Education Sector Development Programme (ESDPI) indicated the intention that non-formal education would provide a second chance to school dropouts and those youths and adults who have never had the opportunity to attend schools, and that out-of-school children
would benefit from an opportunity to become literate through non-formal education. However, ESDPI didn’t give much attention to this area. By contrast, ‘alternative basic education programmes’ (particularly those offered by NGOs) play an important role in ESDPII as a means to achieve universal primary education by 2015. Besides the provision of Alternative basic education, some NGOs have been also provided children of the ABECs with stationery materials, uniforms, text books and medical support. However, in Ethiopia, almost all NGOs are donor resources oriented and executed their programs with donor driven agenda and time frameworks.

5.3.5 Extended family support

Although children ability to approach and utilize the social support system was one major determinant factor for efficacy of child-headed households, the positive response made by extended families and the community have also paramount importance. According to respondents, child headed households are expected to adhere promises and other sanctions of parents regardless of its utility to the children current affair. In the face of this fact, some children with child-headed households are reluctant to go in line with parental obligation and prefer their own style of life. What’s more, Parents’ positive image and benevolence prior to death have effect on the quality and quantity of supports children will receive from neighbors and extended family members. Most children involved in the study indicated that depending on parents past history disadvantaged children maybe victim of social reciprocity. Besides, there was circumstance that children faces social exclusion. On top of this fact, however, family past history was not considered as an end by itself. Children involved in the study also signify the role of coping strategies and resilience. Children ability to go in line with social norms and acceptable standards was found to be important source of social support.

The family ties were strengthened by regularly visits to family members and coming together for a prayer or a ceremony (Mkhize, 2006: 187). Because the extended family structure is viewed to be weakened, it is often argued that these structures need to be supported and strengthened. Although it is not always clear how this should be achieved, ‘the community’ is usually seen as an important actor. Even if there are a number of indications that the extended family will in future be unable to continue absorbing orphaned and vulnerable children, traditional family and community structures in Ethiopia has positive trends in supporting disadvantaged children.
Qualitative data clearly pointed out that Extended family supports play a vital role in preventing family disintegration among child-headed households.

5.3.6 Economic difficulties

Household headed children not only take on major household chores, like cooking, washing and decision making but strive to earn a substantial income which can enable them to manage their household expenses.

Almost all research participants were engaged with part-time and lower payment jobs such as conducting taxi, shoe shine, garage and domestic works. Evidently, children income is not enough to carry on household needs and most siblings and household heads were deprived from basic needs such as balanced and adequate food. Participants were asked whether they had some food reserve or store to cope up with an unexpected situation of loss of income or resources for food purchase but all child-headed households said they had no food reserve. Apart from food insufficiency, they are facing tangible difficulties such as frequent illness and financial limitation to access medical services, living in dirt house exposed for wind and rain. As stated on qualitative data, over half of the children are affected by some illness. Children complain of stomach problems in the form of diarrhea and vomiting, headaches and prolonged weakness. Poor quality of drinking water and lack of access to personal hygiene facilities in the study setting greatly risks children health.
5.4 What are the roles of key stakeholders in the provision of care and support for child-headed households?

5.4.1 The role of women, children and youth affair office (WCYA)

Although the role of sub-city and woreda women children and youth affair office seems significant for addressing disadvantaged children at grassroots level, it was found that WCYA has no a well-defined method of collecting, managing and reporting information about child-headed households situations and services. Research participants clearly pointed out that WCYA has no well documented evidence about child-headed households at woreda or sub-city level.

In support of this argument, it was found that role of women children and youth affair office was limited to facilitation roles, recruitment and placement of children to NGOs, and service delivery follow-up. Participants argued that WCYA has obligation to identify truly child-headed households who are in need of care and support from local government and private institutions and community members including Iddirs, religious organizations and individual community members to improve care and support for child-headed households.

Coordination of care for child-headed households and vulnerable children is an important component that helps to address more children in need and help stakeholders to work together for common goal. Yet, there is lack of clarity on how to ensure accountability of the parties involved. Data from qualitative methods shows that women children and youth affair office was the most important government body at woreda level for coordinating various support services for needy children. However, the quality of services given for children was questioned by respondents. Subjective recruitment of beneficiaries and lack of accountability and responsibility were among the concerns raised by participants.

5.4.2 The role of Community volunteers

Community volunteers are members of the community who are identified by disadvantaged children. Most of them are provided with relevant trainings and are responsible for supporting children and their families. They are the front line in implementation of child focused Programs.

Apart from spending time with Child headed households during holyday, volunteers are also provide food and psychosocial support for children. Besides, research participants clearly depicted that educational, moral and disciple related supports were given for children.
Furthermore, community volunteers are provided with various trainings that they, in turn, share with children and guardians. The following are the major roles played by volunteers.

- Identification and registration of potential beneficiaries
- Carry out vulnerability assessment
- Advice family members on how to care for their children
- Follow and guide children on their education
- Advice caregivers on self-reliance and how to start income generating activities
- Train caregivers on parenting and truck on they apply the skill for improved child care
- Advice Child-headed households and their families on personal hygiene
- Facilitate linkage between caregivers with sick child with health facilities for medical support
- Raise community awareness on Child-headed households and sustainable care and support
- Maintain strong and close working relations with caregivers and children
- Resource mobilization, referral and networking

5.4.3 The role of community based organizations (CBO)

When knowledge of the CBOs about child-headed households was assessed, 100% said they knew about child-headed households. Major source of knowledge includes, Report from community volunteers, home based visit or supervision and when there is complain from the community regarding orphan and vulnerable children. Most key-informant interview participant’s associate child-headed households with slum areas because most residents of child headed households live in plastic houses exposed for rain and wind, there is no safe water supply and latrine, they are prone for pests and insects and most of the time children were slept in the ground.

Comparatively CBOs has been able to effectively identify child-headed households and work with community structures and local resources. Capacity of the community based organizations to care for child-headed households were developed through resource mobilization. Local resource mobilization was the primary source of income for CBOs. Resources mobilized from within the community have helped CBOs to provide educational materials, construction and
renovation of depleted houses. Similar opinions were reflected on the role of CBO which coordinates disadvantaged children care and support at community level by mobilizing community resources and sustaining initiative activities.

Another important activity that the CBOs undertaken in order to achieve its objective was strengthening community coalition through arbitration to meet the need of disadvantaged children at all levels.

5.4.4 The role of faith based organizations (FBO)

Evidence on whether a member of child-headed household received spiritual or emotional support from spiritual leaders shows that none of the households had received any of the services. Qualitative data shows that faith based organizations provide school tuition fee and other scholastic supports for orphan and vulnerable children but the role of individual members (priests) was not clear or minimal. Since child-headed households were devoid of adult support and supervision, the role of spiritual and psychological support will have paramount role in preventing psychosocial crisis. In addition to material support, all rounded services such as spiritual counseling must be considered.

5.4.5 The role of Nongovernmental organizations (NGOs)

NGOs play a variety of roles in supporting child-headed households including education service delivery. Some NGOs are primarily involved in parenting skill training for household headed children and food and nutritional support. Furthermore, shelter and care, legal protection, health care and psychosocial supports were given for disadvantaged children through nongovernmental organizations. NGOs are also provided community volunteers with relevant trainings and are responsible for looking after highly vulnerable children. Qualitative Findings show that some NGOs are also engaged with income strengthening activities and facilitating vocational training for guardians and older orphans who turn 18 years of age. Yet, there is a contradiction in terms of children interest and NGOs programs concerning income generating activities. Most NGOs are programmed on the provision of educational related support for children. However, there were situations that children who are under 18 will be benefited from income generating activities to support their family including household headed children.
Before the new charity organization proclamation ratification, one major intervention area of NGOs was advocacy aimed at putting pressure on governments to fulfill their commitment to Education and other supports for disadvantaged children. However, after enactment of the law NGOs weren’t in a situation to enforce the government regarding priority areas.

5.4.6 The role of school settings

Schools have become one of the most important settings where preventive and wellness promotion interventions for orphan children are conducted. This is due in part to the convenience of conducting interventions in a setting where the target population spends the majority of its time. It also reflects the fact that in addition to their central role of fostering academic development, school serves an important role in the health and socio-motional development of orphans.

Participants clearly suggested that spiritual disturbances, trauma, bereavement, stigma and discrimination either prevented orphans and vulnerable children from attending school or limited their performance in the classroom. Furthermore, Qualitative data from school revealed that performance of orphans was affected by frequent absenteeism to work and physical exhaustion after work. However, finding from school revealed that some orphans were seen to be performing in school better than non orphans.

Research participants underscore the need for quality of education and safe school environment for better educational outcome. Better education increases orphans cognitive-emotional and intellectual competencies and job prospects, and contribute to reduced social inequity and lowered stigma and discrimination and reduce certain mental disorders such as depression (UNICEF, 2002).
Conclusion

From the beginning, the HIV/AIDS epidemic has been accompanied by fear, ignorance and denial, leading to silence and little response by governments. Children orphaned and otherwise affected by HIV/AIDS have paid a harsh price for this failure to act.

Although some improvements have been reported from the government of Ethiopia with regard to access to education, health care and psychosocial support, the situation for vulnerable children and orphans in particular remains desperate and complicated. Given the current level of food insecurity in Ethiopia, orphan and vulnerable children appear to be worse off than they were in the past and there is little sign that the situation will improve anytime soon. Child-headed households were still more likely to be denied healthcare than adult-headed households. This was seen to be due to lack of adequate care and financial constraints.

Early traumatic events and lack of care and sensitive responsiveness by the community and government can harm the development of children leading to chronic vulnerability to stressful conditions. A healthy start in life greatly enhances a child’s later functioning in school, with peers, in intimate relations and with broader connections with society. Psychosocial difficulties of child-headed households and orphans are compounded by feeling of abandonment and lack of responsive care.

Many of the tasks that children in child-headed households take on, the time spent on these tasks and the extents of the responsibilities are assumed to be much greater and age inappropriate. The importance of neighborhood and extended family supports for enhancing efficacy of child-headed households was unquestionable. Emotional and psychological supports in particular have far reaching implications for child-headed household’s future wellbeing. Research on children household capability and interventions for household efficacy may prove useful for child-headed households.

In spite of multifaceted difficulties, the majority of child headed households appear to be well-adjusted. They appeared more responsible than others in their community. Children readiness to support and care for siblings should be supported by the government and much more decisive action is needed to ensure wide spread and consistent care for child-headed households.
Finally, and perhaps most significantly, governmental action has been slow to emerge because families and communities have shouldered most of the strain. Ethiopian traditions of community cooperation have relieved the pressure on governments and national institutions. The researcher recognized that in the research setting poor families are supporting child headed households with minimal assistance, including from the government and national political commitment and resources are insufficient. Communities are at the forefront of caring for orphans and vulnerable children.

**Recommendation**

**Government (MoWCYA, MOLSA and CSA)**

- Evidence generated from this study reveals that child-headed households and their problems aren’t documented and data base is not available at different levels. Associated capacities are not developed at different levels as well. Availability of such data is believed to improve child-headed households programming as well as contribute to policy dialogue as concerns orphan and vulnerable children. In connection to this, Central statistics agency should consider child-headed households in household surveys adequately.

- Further to Ministry of women, children and youth affair, it is expected that Ministry of Labor and Social Affairs have to play indispensable role in identifying and enrolling Child-headed households for various services. Furthermore, the office along with women, children and youth affair work collaboratively to ensure proper provision of services and facilitate partnership among other stakeholders. Yet, qualitative data from labor and social affair at sub-city and woreda level depicted concern over the limited capacity and knowledge about child headed households. This may affect motivation and sustainability of their engagement. Thus, it is recommended to incorporate child-headed households’ part of priority action areas and develop a strategy where child-headed households fully engaged.

- Action against HIV/AIDS has to be a shared national responsibility. No single stakeholder has the capacity to respond unilaterally to a crisis of this complexity and magnitude. It is vital therefore to ensure that information about child-headed households and the steps needed to support is available to everyone- policy makers, community
leaders, organizations and the public. Besides, coordination of care and support at various levels should be given special priority.

**Non-governmental organizations (NGOs) and other stakeholders**

- The proportion of orphan and vulnerable children who had HIV test and accessed ART over the previous year has shown improvement. However, by considering the size of orphan population in Ethiopia pediatric HIV testing and counseling was still very low and needs organized effort. HIV testing and counseling is an entry point to the continuum of care and is an important component of HIV services. It is even more important for Child-headed households as this group has elevated HIV risk because of their vulnerability. Considering this fact, more focus on increasing HIV counseling and testing coverage for orphan and vulnerable children is required.

- Expanding economic strengthening seems essential as the need for this service was found to be high while a relatively small proportion of households were engaged in the service. Also, in order to enhance and sustain benefits of economic strengthening of child-headed households it is recommended those in-school youths who head households should be supported along with schooling. However, it’s very important to make sure that economic strengthening activities shouldn’t affect children education.

- Strengthening Alternative basic education with the aim of providing educational opportunities to those children excluded from government schooling. Educational exclusion that such provision intends to address can take many multidimensional forms. It is often associated with being ‘hard-to-reach’ in terms of where children live as well as who they are. Street children, orphans and vulnerable children, child-headed households, children with disability, and child laborers are often amongst those identified as being most excluded from government provision.

- Strengthening capacity of child heads and survival skills to better equip them for newly acquired household responsibilities and to protect them from HIV infection. In order to achieve sustainable impact on child headed households by improving care, coverage of better parenting training for child-heads should be improved.
Education bureau and schools

- Interventions to enhance school enrolment, attendance and retention include reducing or eliminating school fees and hidden costs, improving the quality of education, introducing life skills development into curricula, and engaging schools as community resources for information, psychosocial support, HIV prevention, and other support functions.

Community based organizations

- One component of care and support service to child-headed households should be renovation of existing depleted houses of destitute households to protect children from exposure to various problems. This may be accomplished through mobilizing local resources from the community by the community.
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Annex 1: In-depth interview guide for household headed children’s

Introduction

My Name is Kidus Bazezew. I come from Addis Ababa University. I am here to discuss about the efficacy child-headed households in caring for orphans. This is voluntary based response. There is no right and wrong answer. All comments, positive and negative are welcome. I encourage many points of view. I would like this to be open discussion, feel free to express your opinion honestly and openly in order not miss any points of the questionnaire. I would like to confirm you that all your comments are confidential and used for the research purpose only. 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. Do you provide any type of support to younger siblings? What type?
2. For how many siblings you care for?
3. What do think is orphans value most?
4. Do you engage in any form of a job to generate income? If yes, please tell us the type of the job?
5. Was it before or after your mother’s/father’s death that you started working to generate income?
6. Where and how do you get your daily food?
7. Could you please express your views as to the adequacy of the food you get?
8. Did you use to go to school prior to your mother’s/father’s death?
9. Have you continued going to school after your mother’s/father’s death? If yes, what grade are you?
10. If ‘No’ why not?
11. Do you have any land or property inherited from your parents? If yes, please specify?
12. How do you evaluate your capability in caring for younger siblings?
13. What factors do you think influences your capabilities in caring for orphans?
14. Do you ever experience stigma and discrimination?
15. Do you receive any support so far?
16. Where do you receive the support?
17. For how long you received the support?
18. How do you evaluate the social support system especially your neighborhood support?
19. How do your friends/teachers respond to you as a result of your mother’s/father’s death?
20. How is your relationship with the extended family? Do you ever come across with any support before & after your parent death?
21. Do you have any comment or suggestions?
Focus Group Discussion Guide for Younger Siblings (orphans)

Possible discussion questions

1. How do explain child-headed household (your living circumstances)?
2. How do you compare parental care with children caring for children?
3. Do you think that older siblings (Household heads) are capable of providing care and support to younger siblings?
4. What are major household roles and responsibilities assumed by younger siblings? (other than household headed children)
5. Did you use to go to school prior to your mother’s/father’s death? If ‘No’ why not?
6. Have you continued going to school after your mother’s/father’s death? If ‘No’ why not?
7. Do you engage in any form of a job to generate income? If yes, please indicate the type of the job?
8. If you’re engaged in any kind of occupation does it bring any life style or life status changes? What type of change?
9. Do you have birth certificate? If no, please specify the reason?
10. Where and how do you get your daily food?
11. Please express your views as to the adequacy of the food you get?
12. Have you ever been sick after your mother’s/father’s death?
13. Have you ever fallen sick with a serious health problem that lasted for more than one month?
14. Have you sought for medical assistance from health center/hospital for this chronic health problem?
15. If ‘No’ why was it that you failed to seek for medical assistant?
16. Have you ever receive any socio-economic support in the last some years& who gave you the support?
17. What kinds of support do you receive & how frequent it was?
18. Do you ever come across with any support from your extended family members since your parent death?
19. Do you experience any stigma and discrimination/abuse?
In-depth interview guide for community volunteers

Possible discussion questions

1. Do you know that there are children looking after children in this community?
2. If so, how do you know about it?
3. How do you see his/her fate if there is no one who can care and be responsible for orphan children after the death of parents?
4. Do you have any prior experiences on volunteerism?
5. If yes, where and how long?
6. Do you continue volunteering for nongovernmental organizations?
7. Does your organization provide any support for child headed households?
8. If so, what type of supports?
9. Do you provide any support for child headed households part of your volunteerism?
10. If yes, what type of support?
11. How many home based visits do you conduct per week?
12. Do you receive any training in looking after orphans?
13. From whom do you receive primary support?
14. Do you have any comment or suggestion?
Key informant interview guide for FBOs, CBOs, Sub-city/woreda women, children and youth affair office representatives.

Interviewee background information

1. Sex__________ age ________________
2. Educational status____________________
3. Interviewee’s position/responsibility in CBO/FBO/GO_____________
4. Objective of CBO/FBO/GO_______________________________________
5. Years of experience in dealing with orphan and vulnerable children________

Possible discussion questions

1. Do you have any information about child-headed households?
2. If so, how do you know about it?
3. What is the general thinking/understanding towards child-headed households?
4. What strategies/service guidelines are there to address the multifaceted and dynamic needs of child-headed households?
5. How do you distinguish child headed households from other vulnerable children?
6. Do you provide any type of support to child headed households? What type?
7. How do you evaluate the effort of your organization for coordination of care and support services to child headed households and other vulnerable children?
8. Is there anyone who works with your organization or establishes network to support your endeavor? (Please list)
9. What do you think is the role of faith based organizations for enhancing the wellbeing of disadvantaged children?
10. What area of socio-economic challenges do you suggest to be addressed in the future? Who should take the responsibility?
Semi-structured questionnaire for NGOs, labor and social affair office, teachers and school principals

Direction: - Write the number of your choice in the box for close-ended questions and write responses for open-ended questions in the space provided.

Socio demographical data
1. Age __________
2. Sex
   1. Male         2. Female
3. Position: ______________
4. Educational Status: __________
5. Number of years working on children: ______________

Part one- questions relevant to NGOs
1. Do you have any information about child-headed households (CHH)?
   1. Yes          2. No
2. If yes, how do you know about it?
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________
3. What socio-economic advantage differences are there among child-headed households and adult/parent headed households?
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________
4. Does your organization undertake any kind of activities to help child-headed households to overcome their problem?
   1. Yes          2. No
   If yes, what kind of activities?
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________
5. What strategies/service guidelines are there to address the multifaceted and dynamic needs of child-headed households?

________________________________________________________________________

6. Do you think that child-headed households have special needs? If so, in what aspects?

________________________________________________________________________

7. Is there anyone who works with your organization or establishes network to support your endeavor? (Please list)

________________________________________________________________________

8. Do you have any home based intervention or community support group who support child-headed households? (Please list)

________________________________________________________________________

________________________________________________________________________

9. Do you have any community volunteer or guardians who look after orphans regularly?

________________________________________________________________________

________________________________________________________________________

10. What are your recommendations/suggestions regarding child headed households?

________________________________________________________________________

________________________________________________________________________
Part two- questions relevant to Labor and social affair office

1. Does your organization have documented evidence about child-headed households at sub-city /woreda level?
   1. Yes  2.No

2. What strategies/service guidelines are there to address the multifaceted and dynamic needs of child-headed households?

3. Do you think that OVCs and CHH are different in terms of needs and concerns?
   If so, how does your organization address CHH needs and concerns?

4. Is there any stakeholders currently working with your office pertaining to child headed households care and support?
   1. Yes  2. No

5. If yes, please tell us type and name of organizations? (i.e., NGOs, CBOs)

6. What is the bureau’s role in coordination of care and support for child-headed households and other vulnerable children?

7. What area of socio-economic challenges do you suggest to be addressed in the future? Who should take the responsibility?
**Part three - questions relevant to school principals and teachers**

1. Do you have any information about child-headed households?
   1. Yes  
   2. No

2. If yes, how do you know about it?
   
   ____________________________________________________________

3. Do you have any information in relation to child headed households in your school?
   1. Yes  
   2. No

4. Does your school provide any type of support to orphan students?
   1. Yes  
   2. No

5. If yes, what type?
   
   ____________________________________________________________

6. How do you evaluate CHH/OVCs school enrollment, attendance and achievement?
   
   ____________________________________________________________

7. Do you have any school based intervention or support groups who assist orphans?
   
   If yes, what type?
   
   ____________________________________________________________

8. What are major socio-economic challenges faced by orphan students? What do you suggest to be addressed in the future? Who should take the responsibility?
   
   ____________________________________________________________
Annex 2: Consent form

You are asked to take part in the study *the efficacy of child headed household in caring for orphans* conducted by Kidus Bazezew in partial fulfillment of the requirements for the Master of Arts degree in social psychology, submitted to the school of psychology, Addis Ababa University. The researcher need to know whether children heading households are effective or not and identifying contributing factors that affects efficacy of shouldering household responsibilities. In addition, the researcher addresses the role of social support mechanisms available for child-headed households. This information will help the effort in addressing complex and dynamic needs of child-headed households in Ethiopia. To protect your privacy, you are not required to give your name.

**Agreement**

I have read (or someone read for me and explained) the information given above and I understand the content thereof. I therefore, hereby give my consent for the use of note taking and to participate in the interview.

Signature of the participant: __________________________ Date: ______________

Name of the person obtaining Consent: __________________ Date: ______________
Annex 3: Partial view of child-headed households