

The Phenomenon and Concerns of Child-Headed Households in Africa

Dr Adrian D. van Breda¹

Introduction

In Africa, parents are often unable to care for their children, due to ill health, death, political turmoil or economic constraints. In the midst of such challenges, many families develop alternative living arrangements as ways of coping. The emergence of child-headed households is one such alternative; a family constellation that, some argue, has a legitimate place within society. Although there is much debate on this point, a child-headed household is typically defined as a family, living under the same roof, which is headed by a person under the age of 18. Others, however, are concerned about the vulnerability of young people caring for themselves – about the costs to their safety, education, social development and health.

This chapter provides an overview of the phenomenon of child-headed households, with a primary focus on South and southern Africa, drawing on a range of literature. In addition, I make frequent reference to a large recent South African study conducted by Chiastolite Professional Services (2008), for which I served as principle investigator. In the first part of the chapter, I give particular attention to the context, definitions and prevalence of child-headed households. In the second part, I provide an overview of some of the main psychosocial concerns of these households, such as family role adjustments and sexual exploitation.

I conducted an extensive review of literature. Twelve information databases were searched using “child-headed household” and “orphan” as key words. The databases included: Proquest’s Academic Research Library, Ebscohost’s Academic Search Premier, Gale Group’s Infotrac, Blackwell’s Synergy, JSTOR’s Scholarly Journal Archive, SAePublications, Science@Direct’s ScienceDirect, SpringerLink, Swetswise, Biblioline’s Africa-Wide NiPAD, UNISA’s Oasis, CSA’s Social Services Abstracts and PsychINFO. In addition a Google search was conducted on the World Wide Web, with emphasis on sourcing unpublished research and workshop reports.

Several hundred abstracts (journals, books, theses) and research reports was reviewed, out of which 80 full text documents were identified as relevant to the study. Most of these focused specifically on child-headed households, but some addressed the broader issues of HIV, orphans or vulnerable children. Emphasis was

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given to African texts and South African texts in particular. Thirty-one of the texts addressed research findings from South Africa, and a further 45 focused on other African countries. Furthermore, emphasis was given to current literature – 75 of the texts were published since 2000.

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Based on a review of the abstracts, I conducted an initial thematic grouping, producing a list of 21 main themes. Thereafter, a detailed review of all papers was conducted so as to create a synthesis of the main available and recent texts concerning the subject of child-headed households. This resulted in a reduction and refinement of the original topics. An annotated bibliography of all the texts can be accessed at www.adrian.vanbreda.org.

Context, Definitions and Prevalence

HIV & AIDS, Poverty and Orphanhood

Before focusing on the main topic of this chapter – child-headed households – we must address the main contextual issues that influence the phenomenon of child-headed households, viz HIV & AIDS and poverty. While there are various factors that can cause orphanhood – for example, in northern Uganda war is the main cause (De Klerk, 2006) and similarly in Rwanda the 1994 genocide created over one hundred thousand orphans (Bregg, 2004) – in South Africa AIDS is a main cause (Anderson & Phillips, 2006).

HIV is different from many other infectious diseases in that it does not target primarily those who are weak, very young or old. Rather, it targets those who are in their most productive years, with infections occurring in their late teens and early twenties, and illness and death occurring in their thirties and forties. “In South Africa, for example, it is estimated that the average age of those dying as a result of AIDS is 37 years” (Pharoah, 2004, p. 1). It is likely that many or most of these people have children, who subsequently become orphans.

Before AIDS, “about 2 percent of all children in countries of southern Africa were orphans. However, by 1997, the proportion of children with one or both parents dead had skyrocketed to 7 percent in many African countries and in some cases reached an astounding 11 percent” (Ghosh & Kalipeni, 2004, p. 304). In South Africa in 1999, 420,000 children (or 8%) were orphans (Ghosh & Kalipeni, 2004, pp. 305-307). It is estimated that by 2014 the number of orphans in South Africa will peak at 5.7 million children (Frohlich, 2008, p. 353) – this is almost double the population of Berlin.

It is likely that, as the HIV pandemic continues to spread and mature, we will see an increasing number of orphans and thus also child-headed households (Rosa & Lehnert, 2003). In a comparison of South Africa with Tanzania and Malawi,

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Hosegood et al. (2007, p. 327) found that “in South Africa – where the HIV epidemic started later, has been very severe, and has not yet stabilized – the incidence of orphanhood among children is double that of the other populations”.

AIDS has a profound impact on social development in Africa. In South Africa, the “average life expectancy is estimated at 47 years instead of 66 years” as a consequence of the AIDS pandemic (Lugalla, 2003, p. 35). Economic growth and income suffer, and poverty is thus exacerbated (ibid.). 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” (ibid., p. 415). “Chronic poverty in the form of multiple deprivations over a

sustained period ... was evident in some families and it affected both orphans and other children” (Jones, 2005, p. 169). 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).

A number of authors have challenged the inadequate South African response to the challenge of orphans (Centre for Policy Studies, 2001). Meek and Rew (cited in De Klerk, 2006, p. 8) criticise the “catastrophe” of orphans in South Africa, saying that “the South African government has no policy, no plan, no institutions, and no budget for orphans.” The challenge is, who should look after these orphans? 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 institutionalised 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 institutionalised children often experience problems in adjusting to life outside of the institution.”

Generally, the literature argues 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 that the resources and capacity of the extended family to provide such care is rapidly and dramatically waning (Boris, Thurman, Snider, Spencer, & Brown, 2006; Centre for Policy

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Studies, 2001; Evans, 2002; Foster, 2004; Freeman & Nkomo, 2006; Ghosh & Kalipeni, 2004; Jones, 2005; Kelso, 1994; Van Dijk, n.d.). Thus, what happens to orphans who can be taken up neither into institutional care nor into foster care? The answer is that most of these become ‘child-headed households’ and the data suggest that these households are on the increase (UNICEF et al., 2002).

Definitions of ‘Child-Headed Household’

Before a direct discussion on what is a child-headed household, we need to address the questions of what is an orphan and what is a household. There is much debate on what is an ‘orphan’. Colloquially, an orphan is understood as a child whose parents have died. In much HIV literature and programme funding, however, an orphan is operationalised as a child whose *mother* has died, which technically is termed a ‘maternal orphan’. This is because patriarchal society typically allocates the primary responsibility for childcare to mothers, rather than fathers, and because the death of the father does not usually result in a change of caregiver while the death of the mother does (Freeman & Nkomo, 2006).

However, one must also take into consideration the notion of ‘social orphans’, which refers to children who have been abandoned by their parents for some or other reason. “In Swaziland, the number of social orphans now exceeds that of natural orphans” (Cornia cited in Jones, 2005, p. 163). One Swazi interviewee stated, “There are different types of orphan. There are orphans where the parents are dead, orphans where the parents have abandoned them, and orphans where the parents can’t afford to care for them” (Jones, 2005, p. 165). Henderson (2006, p. 307) also points to children who have been displaced through, for example, war and concludes that “to be orphaned in this sense is to be without moorings, social support and place”.

A comprehensive definition of an 'orphan' is "a person under 18 years of age, who has lost one or both parents to death, desertion or other means" (Freeman & Nkomo, 2006, p. 504). This definition is sensitive to the variety of ways in which children lose parental care, and recognises that childhood continues into the late teens. However, the South African Children's Act of 2005 defines an orphan more strictly as "a child who has no surviving parent caring for him or her" (South African Government, 2005a, Section 1), which effectively means a double orphan where both parents are dead. A 'child' is defined in the Children's Act of 2005 as a person under the age of 18 years (*ibid.*).

The question of what is a 'household' is also an important consideration. "The household is usually the primary unit of analysis [in studies of the impact of HIV and AIDS]. It is convenient, consistent with prior studies, and meaningful, since the household is a recognizable economic unit and standard definitions exist (whether

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'members eat from the same pot' or 'sleep under the same roof')" (Murphy et al., 2005, p. 269). The problem with the construct of 'household' is that it is highly fluid – family members may not live in the household, other non-family members may live in the household, household membership may change rapidly over time (*ibid.*). Some researchers attempt to accommodate this by addressing not only the household itself but also the extended family which is connected with the household (*ibid.*).

In light of our understanding of orphans and households, we come to what is a 'child-headed household'. Unfortunately, the Children's Act of 2005 (South African Government, 2005a) does not define 'child-headed household' although the term is used three times. The draft Children's Amendment Bill (South African Government, 2005b, Section 137.1), however, states that "a provincial head of social development may recognise a household as a child-headed household if:

- (a) the parent, guardian or care-giver of the household is terminally ill, has died or has abandoned the children in the household;
- (b) no adult family member is available to provide care for the children in the household;
- (c) a child over the age of 16 years has assumed the role of care-giver in respect of the children in the household; *and*
- (d) it is in the best interest of the children in the household."

This definition adopts a broad understanding of the causes of a family being 'child-headed' – beyond only orphans to also include children who have been abandoned and even children whose parents are too ill to care for them. The main challenge with this definition is that it requires the household head to be *over the age of 16 years*. Given that a 'child' is defined as someone under the age of 18, this effectively restricts child-headed households to those in which the household head is 16 or 17 years of age, no younger and no older, a period of just 24 months. The rationale for this is, presumably, to avoid households being headed by younger children who should 'ideally' be placed in alternative care.

Section 137.1.b, concerning the unavailability of adult care, creates some ambiguity. Child-headed households are, in fact, seldom entirely without adult or family support. Indeed, child-headed households may be "a mechanism used by the extended family to deal with [a particular] situation" (Bower, 2005, p. 2). It seems that the child-headed household is sometimes a temporary measure while the extended family organises itself (Foster, Makufa, Drew, & Kralovec, 1997). In other cases, there are extended family members

living nearby, who provide “material support, supervision and regular visits” (ibid., p. 166). Another instance is those families in which the parent is too ill (with AIDS, TB or malaria) to care for the children; rather the children are caring for the parents (Chikwendu, 2004; Sloth-Nielsen, 2003). “They ran errands for their parents, and seemed to do household

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chores like sweeping and carrying pails of water from morning till evening” (Yamba, 2006, p. 206, reporting on Zambia). These are often termed “accompanied child-headed households” to indicate the presence of an adult (International HIV/AIDS Alliance, n.d.).

A study in Zimbabwe, for example, found that some child-headed households incorporated “grandparents who were too ill or debilitated ... or blind or old ... to supervise the households; ... a mentally retarded mother; ... aunts [who were] living in the same household but ... not responsible for the daily supervision of orphaned children” (Foster et al., 1997, p. 159). Although adults were present in these households, the researchers still regarded them as child-headed because the adults did not take on the role of household head. Thus this conception of a child-headed household is *functional* rather than demographically defined.

Prevalence of Child-Headed Households in South Africa

Calculating the number of child-headed households in South Africa is a complex task, exacerbated by the lack of accurate data. Ziehl (2002, p. 441) notes that according to 1996 census data, there are approximately 183 thousand child-headed households in South Africa. However, 17% of these household heads are under the age of five, which Ziehl argues is impossible and indicative of recording or transcription errors. Furthermore, she argues that most of the adolescents who are recorded as household heads were probably merely the person with whom the interview was conducted and incorrectly recorded as the ‘household head’.

Prevalence is complicated by the slippery nature of the concept. The notion of a ‘household head’, for example, is diverse, as Richter (2004, p. 18) explains:

“There is ongoing debate about the meaning of both women-headed households and the criteria by which individuals are designated the head of the household. It is uncertain whether such designations are made on the grounds of moral authority, earnings, decision making or presence in the home and responsibility for day-to-day household functions. It is also not clear what level of responsibility is accorded, or expected of, people designated as household heads. Given this debate, notions of what constitutes a child-headed household are even less clear. Teenagers have for many years looked after households in rural areas while mothers migrate on a weekly, monthly or longer-term basis to work as domestic workers in nearby cities and towns. Such figures also fail to reveal how many households consist only of children, or of the level and frequency of support available to them.”

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The complexity of estimating the prevalence of child-headed households is well illustrated in Chiastolite’s (2008) research in South Africa. Using 2001 census data², we found that 7,270 of the 2.1 million households in the Gauteng province were headed by children (a person under the age of 18 years). Using a multifaceted and extensive community mobilisation process, including a team of 104 field workers walking most streets in the province, we obtained notification of 6,039 child-headed households from schools, health

² These data are freely available on the web at <http://interactive.statssa.gov.za:8282/webview/>

clinics, churches, welfare organizations, state agencies and direct reporting through a toll free telephone service. A team of field workers visited every one of these contacts, of which only 63 were in fact child-headed. The majority of contacts (77%) were adult-headed households, with a further 19% having moved and 7% being headed by a young person aged 18 or older.

Concerns of Child-Headed Households

My review of the literature identified 12 key themes regarding the psychosocial concerns of child-headed households. A review of all of these is beyond the scope of this chapter, which will focus on six of them, viz: role adjustments, emotional and social distress, economic survival, sexual exploitation, food and nutritional needs, and education and schooling. The other six themes are: the extended family's capacity to care, migration of children following orphanhood, social security, health care, childhood resilience and community responses.

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.

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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.

The Chiastolite study (2008) found that the taking up of new responsibilities and roles was a highly salient theme. One child indicated, "It is very difficult to act as a mother, a student and a counsellor all at once," and another said, "I have to take care of my little siblings by myself, especially Caroline, who's always sick and needs health attention." The children in our study reported that day-to-day tasks, such as cleaning, washing, ironing and household maintenance, were the most burdensome tasks they have to perform. Cooking and the generation and management of finances were enjoyed the most.

Emotional and Social Distress

Orphanhood is associated with psychological and emotional trauma, as well as social distress. "In a scenario where a large number of children affected by HIV/AIDS in Africa and other parts of the world are exposed to on-going traumatic stress, failure to support children to overcome such trauma will not only jeopardize personal development but, given the scale of the problem, could also undermine years of investment in national development as such children grow to adulthood and are required to take on productive, leadership and parenting roles" (Germann, 2004, p. 95).

A study in Uganda found that, when other variables were controlled, orphaned children evidenced higher levels of psychological distress than matched nonorphaned children (Atwine, Cantor-Graae, & Bajunirwe, 2005, p. 560): "Orphans had higher levels of anxiety and depression symptoms and more frequently endorsed those BYI [Beck Youth Inventories of Emotional and Social Impairment] items that are considered to be especially sensitive for the detection of

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depressive disorder in children". These sensitive items addressed vegetative symptoms, hopelessness and suicidal ideation. The researchers concluded that more than just material support was needed – counselling and psychological/emotional support were also required.

Another study in Kwazulu-Natal explored the life narratives of children in child-headed households compared with adult-headed households (Donald & Clacherty, 2005). They found that while most (92%) of the events mentioned by children from child-headed households were negative, only 55% of events mentioned by children from adult-headed households were negative. Furthermore, all child-headed households reported experiencing the death of at least three close relatives, compared with only a couple of the children from adult-headed households. Many of these children seemed not to have dealt with their grief and loss.

Grief is a common feature, given that these children have lost one or both parents, and in the case of child-headed households have often been spurned by other family as well. There is some evidence that children in Africa participate more fully in death and funeral rites than children in the West, a practice which facilitates grieving and thus grief resolution (Yamba, 2006). Nevertheless, Nkomo's (2006) qualitative study in Gauteng and Kwazulu-Natal highlighted the central experience of grief among children who were household heads. This grief was related to the multiple deaths that many of these children had endured and complicated by having to care for younger siblings with little or no external support. In the Chiastolite study (2008), multiple losses were apparent. One child said, "My mother's voice is hearable in my dreams and that fills sorrow into my heart. I always think about her, even when I'm at school," while another said, "I've got used to accept the fact that my mother is never coming back and doesn't care. Thus, I have to survive on my own."

Depression, at clinical levels, was common among youth (aged 13-24) who headed households in Rwanda (Boris et al., 2006). Of interest, "heads of household who reported higher levels of depressive symptoms, social isolation, and/or lack of adult support were also more likely to report that children under 5 in the home were showing more signs of socioemotional disruption" (Boris et al., 2006, p. 598). A study in Uganda, which found depression to be higher among orphans than matched non-orphans, also found that depression among orphans was associated with smaller household sizes, which suggests

the potentially buffering function of a larger support system (Atwine et al., 2005). A study in Namibia found concerning levels of suicidal ideation among child-headed households (Ruiz-Casares, 2006).

Anger was a common feeling experienced by orphans and vulnerable children (OVCs) in the USA, related to feelings of abandonment by their parents and compounded by often having to care for a dying parent (Paige & Johnson, 1997). A study in Uganda found that orphans experienced significantly higher levels of anger

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than matched non-orphans (Atwine et al., 2005). Henderson (2006, p. 312) relates the narrative of a South African orphan, saying “her evident stoicism was underpinned by anger.” Within the context of Henderson’s paper, this 13-year-old child’s anger can be viewed as a strength – an appropriate response to a number of violations (poverty, death, abandonment) that girded her to cope with life’s demands.

Children in the USA often reported anxiety about having to maintain secrecy regarding HIV and AIDS in a context that stigmatises and discriminates against people with HIV and AIDS (Paige & Johnson, 1997). A study in Uganda found that orphans experienced significantly higher levels of anxiety than matched non-orphans (Atwine et al., 2005).

Stigma is a common experience among many child-headed households, because their parents died of or are assumed to have died of AIDS (Segu & Wolde-Yohannes, 2000). This is associated with the experience of social exclusion – in a Rwandan study, 86% of orphans indicated that they felt “rejected by the community” (Thurman et al., 2008, p. 2). A third of the children (35%) in the Chiastolite study (2008) indicated that their communities treated them differently because they are in a child-headed household. They said: “People in the streets look at you as if you are a different species,” and, “My peers are judgmental and that makes me sick.”

A study in Zimbabwe found that children in child-headed households experienced a significant amount of fear about the future (Walker, 2002). Half of the children were fearful about losing their house, a quarter feared living in poverty for the rest of their lives and a fifth were afraid that life would become increasingly difficult. Some children were afraid of becoming ill or dying of AIDS. Children feared being separated from each other, a concern that was particularly prominent in the Chiastolite study (2008).

A study of child-headed households in the Free State province of South Africa found that some children experienced a feeling of vulnerability, the absence of a feeling of security (Leatham, 2006). They feared for their safety, worrying about being physically attacked or mobbed. The children compensated by being careful to be home before dark, avoiding drug and alcohol use and having fewer friends. Another study in Gauteng yielded similar findings (Masondo, 2006). There are reports that child-headed households are in fact vulnerable, as robbers perceive them as having large amounts of cash from their parents’ policies (Khupiso, 2007). In the Chiastolite study (2008), three (out of 61) children reported having been victims of crime during the past year (two of whom were mugged) and ten reported that they were abused in the previous six months, most of whom experienced physical abuse. For example, children said: “My neighbour hit me because I left my 9 year old sister

alone one Saturday morning. He claimed I was irresponsible and deserved a clap [slap] in the face,” and, “The uncle abuses us emotionally when he is drunk.”

Economic Survival

Studies suggest that child-headed households are much more economically vulnerable than adult-headed households. “In several countries, income in orphan households has been found to be 20–30% lower than in non-orphaned households” (Richter, 2004, p. 9).

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 (on non-school days), 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. In two child-headed households, rent from a room in the house constituted a more regular income. Most child heads of households also mentioned irregular gifts of money or food from relatives, and help with food from neighbours if they asked” (ibid., p. 24).

In a qualitative study in the Free State, coping economically was one of the main themes to emerge (Leatham, 2006). The household heads reported stress about the responsibility for caring financially for the family – where to get food, where to live, etc. The limited resources led to conflict between family members regarding the spending of funds. The lack of funds made it hard to fit in with other children, for instance not having money for school uniform or to go out for socials with peers. Many of the children reported doing odd jobs to supplement the money they get from grants.

Children are also vulnerable to economic exploitation. There are reports of children being chased out of their homes by relatives who claim to have inherited the house from the children’s deceased parents (Rosa & Lehnert, 2003). There are also reports of child-headed households being robbed by opportunists who believe they have received large life insurance and funeral scheme payouts (Khupiso, 2007).

The Chiastolite study (2008) found that, by matching the individual household sizes of each family with its reported total monthly income, almost half (44.3%) of the child-headed households in the survey were living in absolute poverty. The majority (51.1%) of the children who maintained that they had very little if any income stated that they had to make do with what they have, as they had no other option. Some

children said: “I have to study by candlelight [because she could not afford electricity] and that’s a difficult experience,” and, “I drive local taxis on weekends to get money for food and other necessities we usually need.”

Sexual Exploitation

Sexual abuse of children takes place in all demographic groups, not only among OVCs. Nevertheless, South African research indicates that it is more frequent among “children living without one or both of their biological parents, children whose primary care giver is absent or unavailable, ... [and] children placed in the care of more distant or unrelated persons...” (Mullen & Fleming cited in Mabala, 2006, p. 416). Furthermore, “in South

Africa, it is estimated that for those under the age of 15, sexual abuse is taking over from mother-to-child transmission as the major reason for HIV prevalence” (Mabala, 2006, p. 417).

Kelso (1994) reports that in parts of Africa, OVCs are turning to commercial sex work to generate an income to help their family survive. Ironically, this exposes them to the risk of HIV and AIDS, the very disease that frequently led to their vulnerability in the first place.

Children in child-headed households are vulnerable to sexual exploitation in the form of sex in exchange for favours, such as food. Yamba (2006, p. 208) reports of a 13-year old Zambian orphan girl, Loveness, who became pregnant by a local politician. “The man regularly brought the family supplies of cooking oil and maize and ... this helped them a lot” making refusal of sex or laying charges against the man very difficult. Loveness became infected with HIV. Some years later, Yamba found that the baby had died and that Loveness herself was dying of AIDS.

Girls, in particular, are vulnerable to sexual exploitation. UNAIDS statistics show that while African girls (aged 15-24) were no more (and probably less) sexually active than boys, they were about two and a half times more likely to have acquired HIV (Mabala, 2006). In South Africa, specifically, 21-31% of girls in this age range had HIV in 2002, compared with just 9-13% of boys (ibid.). “Hundreds and millions of girls and young women living in the path of HIV have had no or limited benefit from schooling, feel unsafe in their communities, face a significant risk of sexual coercion and – having few or no assets or livelihood prospects – have been compelled to exchange sex (inside and outside of marriage) for money, gifts, food and shelter” (Bruce & Joyce cited in Mabala, 2006, p. 409).

In a small study of child-headed households in Zimbabwe, 40% of the children interviewed reported some form of abuse since becoming a child-headed household (Walker, 2002). The forms of abuse included being beaten, being shouted at or called derogatory names by adults, being sexually abused and being made to work

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for little or no money. In a study in Gauteng one of children reported sexual abuse by her uncle (Masondo, 2006).

In the Chiastolite study (2008), while almost half of the children (28 of 61) reported that children in child-headed households are vulnerable to sexual abuse and rape, none of them reported having been sexually abused or raped in the previous six months.

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. A study in South Africa found that families that took in orphans experienced lower levels of food security compared with those without orphan children (ibid.), which could explain some of the reluctance of extended families to take in orphaned relatives. 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).

Nevertheless, despite these expectations and despite measurable differences in family income between child-headed and adult-headed households, a small comparative study in

Kwazulu-Natal found no significant differences in Body Mass Index between children in these two types of households (Donald & Clacherty, 2005). In another report on apparently the same study, it was found that while children in child-headed households had a good understanding of the range of foods that they needed, the food groups that they actually had in the house were limited, and excluded “meat/protein foods, fruit, bread and soap/toiletries” (Idasa, n.d., p. 21).

A small study in Zimbabwe concluded that all of the child-headed households interviewed were food insecure (Walker, 2002). Although the households were in a rural area, only a quarter of them were attempting to grow their own food. The researchers believe “this was generally because the children were having difficulty coping with all of the responsibilities of their lives and did not have the ‘energy’ to do more” (ibid., p. 13). None of the families ate regular balanced meals, and some reported regularly having no food at all in a day or being anxious about getting food.

The Chiastolite study (2008) found that most children had two or three meals per day, however, several reported obtaining their food from neighbours, friends or school feeding schemes. A few reported begging for food or for money to buy food. Although vulnerable children are eligible to receive food parcels from the Department of Social Development, only a quarter (27.9%) did. Half of those who did not receive food parcels said they were unaware of them: “Where does one get

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free food? It sounds unreal to me,” and, “I’ve seen people carrying food parcels around but do not know where they get them. Such groceries might help my household because it is difficult to buy your own food if you are not working.”

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; Robson & Kanyanta, 2007), 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; Kakooza & Kimuna, 2005; Richter, 2004). The cost of schooling is not restricted to school fees (which are sometimes waived), but also to learning materials (eg 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). Other reasons for dropping out include “economic stresses on households, changes in family structure, new responsibilities to care for the sick, the elderly or siblings and loss of parental guidance” (ibid., p. 423). A study in Zimbabwe found that 40% of school age children in child-headed households were not attending school (Walker, 2002). A study in Kwazulu-Natal also found that many children in child-headed households had had to abandon school either temporarily or permanently in order to care for ill relatives or to manage the running of the household (Hartell & Chabilall, 2005). Similar findings are reported in India, where two

thirds of child household heads had dropped out of school (India HIV/AIDS Alliance & Tata Institute of Social Science, 2006).

Research indicates that orphans have a much higher school dropout rate than non-orphaned children, which contributes to the cycle of poverty (Kakooza & Kimuna, 2005). Education is regarded as a key factor in working for a future that is free of HIV and AIDS and that has reduced levels of poverty. Orphanhood thus is a great challenge to the goals of social development (Yamba, 2006).

A small study in Kwazulu-Natal found that child-headed households, in comparison with similar adult-headed households, were less able to pay school fees, buy uniforms and organise transfer documents when moving between schools (Donald &

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Clacherty, 2005). Although some children reported having their school fees waived, they still struggled with the cost of books and uniform. Furthermore, a number of children reported various forms of humiliation for their financial difficulties, such as being made to stand outside of classrooms or refused permission to progress to the next grade. The children from child-headed households were more likely to report having had to temporarily drop out of school due to financial or other problems. Another study in Kwazulu-Natal yielded similar results (Mkhize, 2006).

A study of child-headed households in the Free State found that most children relied on teachers for support, and only a few had had negative experiences in which teachers were insensitive to the demands of being both a learner and a household head (Leatham, 2006). The children reported feeling supported by their teachers, regarding their teachers as surrogate parents or role models and obtaining advice and practical assistance from teachers.

Although balancing the demands of managing a household with schoolwork is daunting, some children manage well and achieve academic success. In a study in the Free State (Shilubana & Kok, 2005), factors associated with academic success were, in the opinion of the children: studying hard; in the opinion of the school principle: strong values and moral character, regular church attendance and a network of adults who check up on the children's school work; and in the opinion of the teachers: commitment and hard work, internal locus of control and accepting their situation and striving to achieve.

The vast majority (93%) of children in the Chiastolite study (2008) were attending school at the time of the study. Three children had dropped out of school because of finances or pregnancy and child care responsibilities – “I cannot go to school because I have a child and there is no one to leave the child with,” and, “I won't say I am not attending school. I am absent more often because I have to work to get money.” Most children (83%) reported that their school knew that they lived in a child-headed household and 74% indicated that the school was supportive or very supportive of them. Half of the children (50%) indicated that their school fees had been waived.

Conclusion

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 and AIDS and poverty are key factors in raising the vulnerability of children. The 'child-headed household' is, however, a slippery

construct; difficult to define and particularly difficult to measure. Small, qualitative studies are most effective at uncovering the life

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experiences of these households, while larger surveys and epidemiological studies find this to be a population hard to trace.

I have endeavoured to show that child-headed households, while in my view an alternative and valid family constellation, are vulnerable in a number of key ways. These children carry a burden of family responsibilities and roles much greater than children in adult-headed households. These responsibilities rob 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. They are vulnerable to sexual exploitation, which frequently is related to their economic vulnerability. Similarly, food security and education often suffer as a result.

This chapter has, however, also hinted at the resilience of these children. The Chiastolite study in particular, but also other studies not reported here (eg. Germann, 2006), suggest that children in child-headed households survive, cope and even thrive. For example, only three of the 109 children surveyed had dropped out of school. Children find creative ways, often without resorting to sex work, to generate a family income. They supervise each other's homework, ensure family discipline, cook and maintain a house.

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

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