REVERSED ROLES AND STRESSED SOULS

Child-Headed Households in Ethiopia

The African Child Policy Forum

Plan

Reversed Roles and Stressed Souls

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The African Child Policy Forum
P.O.Box 1179, Addis Ababa, Ethiopia
Tel: +251 (0)116 62 81 96/ 97
Fax: +251(0) 116 62 82 00
Email: info@africanchildforum.org
Websites: www.africanchildforum.org
www.africanchild.info

ACRONYMS

ACORD	Agency for Cooperation and Research in Development
ACPF	African Child Policy Forum
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
CHH	Child-Headed Household
CSA	Central Statistics Authority
HIV	Human Immunodeficiency Virus
NGO	Non-Governmental Organisation
SNNPR	Southern Nations, Nationalities and Peoples' Region
UNAIDS	United Nations Joint Fund on HIV/ AIDS
UNHCHR	United Nations High Commissioner for Human Rights
UNICEF	United Nations Children's Fund

The African Child Policy Forum is an independent pan-African policy advocacy centre based in Addis Ababa, Ethiopia. Its mission is to put the African child on the political and public agenda, focusing on the development and implementation of effective policies and laws. The work of the Forum is rights-based, inspired by universal values and informed by global experiences and knowledge. The Forum aims to provide opportunities for dialogue, contribute to improved knowledge of the problems facing African children, identify policy options and strengthen the capacity of NGOs and governments to develop and implement effective pro-child policies and programmes.

The African Child Policy Forum
P.O. Box 1179, Addis Ababa, Ethiopia
Tel: +251 (0)116 62 81 96/ 97
Fax: +251(0) 116 62 82 00
Email: info@africanchildforum.org
Websites: www.africanchildforum.org
www.africanchild.info

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Author: Shimelis Tsegaye, African Child Policy Forum
Editor: Sarah Howard, African Child Policy Forum

Real names are withheld in this report and sayings are reported under purely hypothetical names. People whose photos and case stories are featured in this report cannot be held responsible for the conclusions and inferences made by the author.

PREFACE

In many parts of Ethiopia, children as young as nine are carrying the burden of supporting their siblings. Child-headed households live a life of hardship and often misery, as they struggle to make ends meet, suffer emotional trauma and cope with a high cost of living. However, their devastating predicament has not been fully exposed, due to lack of research and information.

Until this study was conducted, most of the data on child-headed households in Ethiopia was only embedded in documents related to orphans and vulnerable children. Evidence on the phenomenon has been solely anecdotal. This lack of information has concealed the peculiar nature of their problems and the kinds of special support they need. Aid to child-headed households has, at best, been combined with support for orphans and vulnerable children.

At continental level, most of the existing data on child-headed households is outdated. This limits its value in informing programmes in the face of Africa's fast changing circumstances. This study was carried out with the prevailing lack of data in mind, and it is hoped that it goes some way to bridging the knowledge gap on the phenomenon.

As a country-wide situation analysis, the study identifies the challenges of these children, as well as the underlying dynamics of the situation. The study has analytical depth and vividly presents cases that properly contextualise the challenges and resilience of child-headed households. It contains a wide range of heartrending cases, including the child of fourteen who relies on the rising and setting of the sun to tell the hour of her mother's ART drug intake, and the fifteen year-old girl who has to cultivate the land by herself to feed her five siblings. The study cogently and sympathetically captures the stressful lives of these children.

The African Child Policy Forum is glad to share the findings of this study as evidence of the plight of child-headed households for use in advocacy, policy and legislation development, social mobilisation and programme design.

Assefa Bequele (Ph.D)

Executive Director

The African Child Policy Forum

EXECUTIVE SUMMARY

In 2005, Ethiopia was home to an estimated 77,000 unaccompanied child-headed households: one of the highest numbers in sub-Saharan Africa, second only to Zimbabwe. The study set out to look into the lives of some of these households through contacting a sample of 66 unaccompanied and 43 accompanied child-headed households in five different towns and their rural surroundings. This summary of the findings and conclusions of the study reveals the difficult conditions in which Ethiopia's child-headed families (commonly referred to as child-headed households in the technical literature) are living.

The majority of child-headed households were found to be headed by children between the ages of fourteen and eighteen. A significant number of the households contacted were being headed by a younger sibling even when there was an older sibling in the family. In terms of gender distribution, more girls than boys are heading households. The average child-headed household size was found to be three, but there are a significant number of households containing five or six siblings. The duration of child household headship was two to four years on average, after which they left the household, died or became adults.

Most child-headed households contacted in the study were established following the death of their parents or care givers from HIV/ AIDS, while some were established after parental separation or for other reasons, including the inability of their parents to provide for their needs because of poverty, health and age-related frailty.

Where existing relatives of the children did not take them in, this was usually because they are themselves poor, have large families or are too old. Children who chose not to be integrated into relatives' households refused because they feared abuse, wanted siblings to stay together as one family or to keep the promises made to dying parents. Some wanted to keep inherited property, land,

housing or small amounts of money from their parents rather than move in with relatives.

In addition to assets, some children inherited debt. Bedridden parents seldom communicate important economic and survival concerns to their children, including money owed from or lent to others, or the cause of their sickness.

The study revealed that child-headed households face tremendous emotional and psychological challenges and live with the constant memory of their deceased parents and their lingering agony and death. The majority of children suffer feelings of loneliness, desperation, traumatic stress following bereavement and stress associated with shouldering an adult role at a young age, low self-esteem, fear, and a sense of alienation.

Half the children go to church or mosque to alleviate their psychological and emotional challenges, while the other half reported feeling a sense of religious disorientation because of growing up without adult spiritual guidance. More children sought counsel from other children in their situation than from neighbours, while very few children sought counsel from medical personnel.

A substantial number of girls heading households and their female siblings faced rapes or attempted rape on numerous occasions. There were also numerous reports of property grabbing by relatives in nearly all the study areas. Physical hazards were reported by some children, mainly attributable to their physical incapacity to carry out certain tasks.

The majority of the child-heads earn a livelihood for their household through daily labour and petty trade, so earn very little. A significant number of girls are engaged in domestic employment, mainly as maids. 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 to economic exploitation, hazardous work, forced labour and physical abuse.

The majority of the children visited for this study live in dilapidated mud houses or under plastic shelters. These conditions not only expose the children to wind and rain but also exacerbate their sense of insecurity at night. Problems of shelter are more severe for child-headed households with bedridden adults, especially those living with HIV/ AIDS, due to the stigma and discrimination associated with the virus.

Children coming from child-headed households suffer from many health problems, including severe malnutrition, diarrhoea, pneumonia, skin problems and stomach pains, caused by unhygienic and insufficient food, housing and environment. Due to the combined effects of poor nutrition, poor health and physical and psychological exhaustion, many of the children in the study, especially the younger ones, exhibit stunted growth.

The study revealed that children from child-headed households face a number of challenges in accessing public health services. Children reported difficulties in articulating health problems to doctors. Medical personnel are also reluctant to give medicine directly to children for fear they will not understand the instructions, which could have potential effects worse than the illness. A number of children said that when they get sick they simply bear the pain or self-medicate with any drugs that are on hand, with potentially fatal consequences. This indicates the sense of fatalism that children have developed and lack of information on the availability of medical services.

A significant majority of child heads do not attend school because they lack the money to cover school expenses, including food to eat while at school, while a slightly lower percentage stated lack of time and scholastic materials respectively, as the reasons for not attending school. Some children do not attend school because they are too tired due to their income-earning activities. The educational problems facing children in child-headed households may be traced to the absence of adult support. Children heading households said that they lack

the maturity and knowledge to give proper educational guidance to their siblings, which compromises their scholastic success.

Nearly all the children contacted said they had little or no time to play, and if they do have the time, they feel more comfortable playing with their own siblings than with other children.

The picture was similar in both accompanied and unaccompanied child-headed households, in terms of their basic needs, gender distribution of household heads and the measures they take to satisfy basic needs. However, the presence of incapacitated adults in child-headed households adds a new dimension of challenges related to the special needs of the adults. Child household heads living with bedridden adults have to cater for their material, medical and emotional needs, in addition to the needs of siblings. Children are often entirely responsible for monitoring drug intake of sick parents, in particular ART, which many adults are taking with little or no food, thus compromising its effectiveness. Most children are physically too weak to move bedridden adults in their care and are not able to take the necessary safety precautions for themselves.

A significant number of adult household members were physically weak due to old age or physical paralysis, or are bedridden due to living with HIV/ AIDS. Therefore adult support with physical labour is largely missing in most accompanied child-headed households, as in unaccompanied child-headed households.

The predominant majority of the children heading households containing incapacitated adults attained only primary level education. This has grave implications for child household heads that are responsible for providing the emotional and health care needs of bedridden adults.

Children living with incapacitated adults were also found to have certain critical advantages over children heading households comprising only of children. A significant percentage of incapacitated adults play a role in advising and counselling children on a variety of issues, provide spiritual guidance, and play

a limited parenting role. Children appreciate the warmth brought by the adults in their family, and their presence also plays a role in deterring potential property and land grabbing, as well as physical and sexual abuse. Incapacitated adult members of child-headed households play a formidable role in keeping children together and stopping them making their separate ways onto the streets.

Child-headed households are a special group, even within the category of orphans and vulnerable children, with their own unique needs and challenges. Due to their limited physical and emotional maturity, child-headed households find it hard to earn a satisfactory living with no extended family network to fall back on, so they need urgent material support.

Alleviating poverty and extending social security mechanisms to all poor families at the community level is an important area of intervention. Efforts also need to be made to offer opportunities for older siblings in child-headed households to generate income, through vocational training and start-up capital. The provision of labour- saving technologies to alleviate the household labour burden is particularly relevant to the situation of child-headed households.

Child-headed households, especially those accompanied by bedridden adults, are in need of such apparently mundane facilities as clocks and sanitary materials to allow them to safely and properly care for their parents. Steps being taken to improve health and prolong lives through clinic and home-based care, treatment for opportunistic infections and ART have to be complemented by appropriate nutritional support.

Psychosocial support for child-headed households is important, as children need love, hope and affection, and someone to turn to for advice, guidance, protection and support in times of crisis, in order for them to develop their full potential. These households also need trauma counselling, including access to play and recreational facilities.

Child household heads need to be better equipped with survival skills so they can shoulder the responsibility of providing for the material and emotional needs of siblings, as well as bedridden adults in some cases.

The enhanced role of teachers in providing extra support at school to child-headed households, in order to fill the void left by parents, is an important area of assistance.

Due to their vulnerability to property grabbing and sexual and physical abuse, child-headed households have to be given special legal and police protection, so they can defend their rights and access legal and police services, such as free judicial representation. There is a need for the legal recognition of child-headed households, so that adequate supervision and support can be ensured, through entities approved by an official body, and directly or indirectly accountable to them. Legal recognition is critically important for formalising support from the government; for example, birth registration, access to healthcare and social security. It can also prevent such children from being dispossessed of their houses, land or property.

In order to continue the vital work of advocacy on behalf of children living in child-headed households, there is a need to conduct further in-depth research into their situation, especially in areas not covered by this study.

Unless urgent steps are taken, millions of children parented by siblings will become adults whose emotional, social and educational development has been compromised.

CHAPTER I
INTRODUCTION

Organisation of the report

The report begins with a brief overview and background on Ethiopia and with a general picture of the situation of child-headed households and orphans and vulnerable children in the country. After introducing the study areas, the report presents a detailed discussion and presentation of the findings before ending with conclusions and recommendations.

Background to Ethiopia

In 2006, Ethiopia had an estimated population of 75.1 million, with under eighteen year olds accounting for 50 percent.[1] Ethiopia is a country with rampant poverty, where 80.7 percent of the population survives on less than US$2 a day. Related to this, life expectancy is 53 years for women and 51 for men.

According to the 2005 Demographic and Health Survey (DHS), one in every thirteen Ethiopian children dies before reaching the age of one, while one in every eight does not survive to their fifth birthday. Malnutrition is a major cause of death among children in Ethiopia. The country has one of the most significant levels of malnutrition in sub-Saharan Africa, with nearly half (47percent) of children under five suffering stunted growth, 11 percent wasted and 38 percent underweight.* Child mortality is exacerbated by poor sanitation and the lack of safe drinking water.

Ethiopia has fought bloody wars with neighbouring Eritrea and Somalia in recent years, and has a history of protracted civil wars and severe droughts. Next to HIV/ AIDS, armed conflict and poverty stand out as the second and third most

[1] Central statistical Authority(1998)

* Ibid

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

In 2005, Ethiopia counted a total of 2.4 million maternal, 3 million paternal and more than 600,000 double orphans,[2] making the country home to the fourth largest orphan population in sub-Saharan Africa after Nigeria, Democratic Republic of Congo and Zimbabwe.[3] 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 2005 Ethiopia had 530,000 children who lost their mothers to HIV/ AIDS and 465,000 children who lost their fathers to HIV/ AIDS. The majority of these children are likely to live with an incapacitated father or mother, leaving them as virtual heads of their households.

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.[4] As of 2007, only 24 percent of people living with HIV have access to ART,[5] 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

[2] UNAIDS (2006) & UNICEF (2003)

[3] ACPF compilation, using UNICEF (2003) and UNAIDS (2006) estimates

[4] Ministry of Health (Ethiopia) (2006) , [5] Ibid.

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 [6] 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.

Figure 1 below shows the 2010 projection of the number of child-headed households in Ethiopia and selected countries in sub-Saharan Africa, based on 2005 data. It shows that the phenomenon of child-headed households, and their devastating impact on children's lives, will be extant in Africa for some time. By 2010, Ethiopia will have around 225,000 child-headed households, or a staggering 675,000[7] children growing up in the care of siblings without the company of adults.

[6] There is a statistically significant correlation between the number of child-headed households and of children orphaned by AIDS,

[7] The average child-headed household size in the country is three

Figure 1: Estimated number of child-headed households (in thousands) in selected countries, projected from 2005 to 2010 [8]

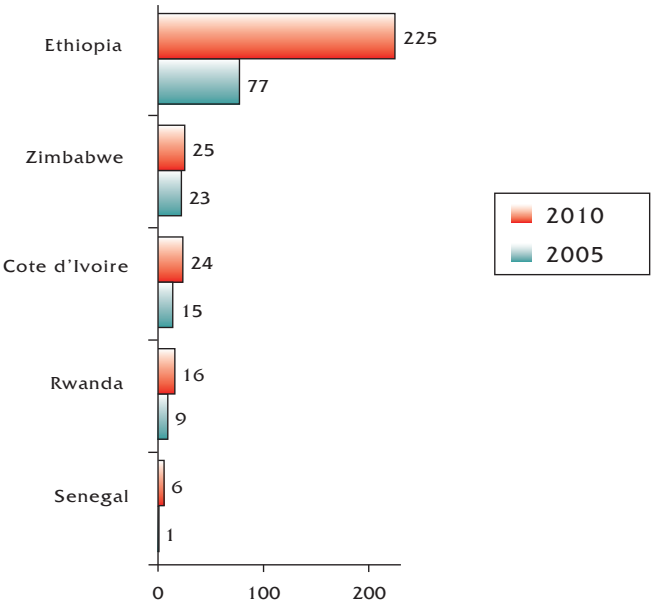


Table 1: Number of unaccompanied child-headed households by region in Ethiopia, 2005 [9]

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

[8] Calculation was based on orphan estimates of UNAIDS (2006), UNICEF (2003) and a number of other sources on child-headed households in the respective countries

[9] Central Statistical Agency (2006b) and Central Statistical Agency (2007)

Problem statement

Ethiopia has one of the highest percentages of child-headed households in Africa. A 2005 survey[10] showed an estimated 522,000 children living in child-headed households with no accompanying adults. Until this study was conducted, virtually no in-depth data was available on the causes, consequences and extent of the phenomenon. Most of the information on child-headed households in Ethiopia was found embedded in literature relating to orphans and vulnerable children in general. The lack of information on the subject masked the specific nature of the challenges facing child-headed households, as well as the special support they need, and their plight has not been sufficiently appreciated by policy-makers and advocacy groups.

At policy level, local and national government officials have very limited knowledge of the extent and impact of the phenomenon. This is borne out by an interview with a regional government official, who said that while they have considerable knowledge about the orphan situation in the country, they only "hear rumours of some children heading households.[11]"In fact, the UN Committee on the Rights of the Child criticised Ethiopia's third periodic report on its implementation of the Convention on the Rights of the Child (CRC), because the report did not mention such a prevalent challenge as child-headed households.[12]

On the advocacy front, due in large part to the paucity of knowledge on the subject, there have been limited efforts to influence legislation and social welfare structures related to child-headed households. As a result, children in child-headed households remain legally excluded from healthcare, education and other support systems because in most cases the presence of an adult in a household is required to allow legal claim of services. These children have often also been victims of property grabbing or groundless claims on inherited land and/ or houses

[10] Central Statistical Agency (2006a)

[11] From an interview held with an expert in the SNNPR Labour and Social Affairs Bureau

[12] UNHCHR (2006)

by opportunist adults in the community, as they do not have the legal status to defend their rights.

Children who are supporting households have to find a way to make a living, which often involves working in exploitative conditions including on the street. They can be denied pay or paid only nominally for their labour. Many girls become victims of rape with the attendant problems of teenage pregnancy and fistula, and boys live with frequent physical abuse and violence. Due to lack of public awareness about their situation, children in child-headed households are considered unworthy of integration into society, and so are not beneficiaries of community-based services.

Study objectives

The study sought to gather empirical evidence on the nature and scope of the phenomenon of child-headed households in Ethiopia, with the ultimate aim of informing policy advocacy and programmatic interventions. Specifically, the study focused on exploring:

- The factors that lead to the establishment of child-headed households, including reasons for the inability or unwillingness of extended family structures to absorb orphans
- The nature, extent and pattern of the phenomenon
- The key problems facing child-headed households, including possible property and land grabbing
- The needs of these households, the survival mechanisms they employ and the associated consequences
- Existing community, NGO and government actions to assist child-headed households and associated constraints
- Community and peer perceptions about child-headed households and their own self perception
- The degree of access to education, healthcare, economic services and other public facilities, and the challenges they face in accessing these services.

Study areas

The study was carried out in the major towns of Addis Ababa, Awassa, Modjo, Dessie and Shashemane. The first four towns were mainly selected because of the presence of relatively large numbers of orphans, whereas Shashemane was selected for its low recorded number of child-headed households, to look at the factors that contributed to this. The rural environs of the towns were also covered, to explore the urban-rural differentials that shape the phenomenon. Respondents involved in the study included child heads of households, both accompanied and unaccompanied; incapacitated adults in child-headed households; child-focused governmental and non-governmental organisations; medical personnel; teachers; community leaders; and other relevant people. In 2006, the four regional states where the study towns are situated, namely Oromia, Amhara, SNNPR and Addis Ababa together accounted for 63 percent of the total number of children orphaned due to AIDS and were home to 87percent of the total number of people living with HIV in the country. Moreover, these regional states together accounted for 88 percent of the total AIDS-related deaths in the country in 2006 [13] and 86 percent of all child-headed households in the country in 2005. [14]

[13] Ministry of Health (Ethiopia) (2006)

[14] Central Statistical Agency (2006b)

Figure 2: Location of the study towns (shown in red)

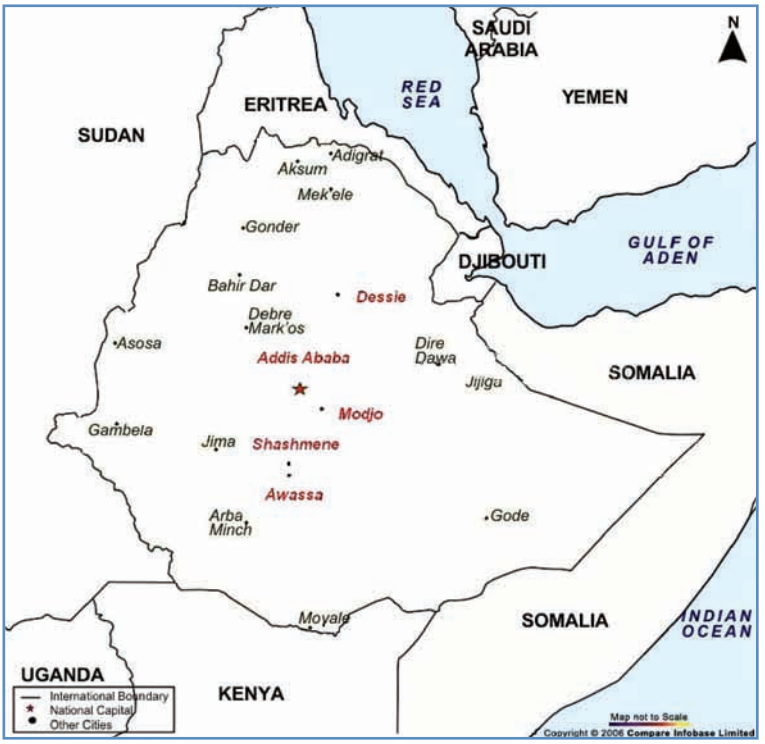


Table 2: Population and surface area of study towns and their rural environs [15]

Woreda/ town	Population	Surface area/ km
Addis Ababa	2,973,000	530.14
Awassa Zuria	532,273	942.35
Shashmene Zuria	350,957	759.53
Dessie Zuria	278,725	1,105.86

[15] Central Statistical Agency (2007)

Definition of key terms

Accompanied child-headed household (accompanied child-headed family): a household (family) where a child is providing income and care to siblings in which the parent/s or primary caregivers are incapacitated by chronic illness, old age or disability

Adult: a person above 30 years of age

Child: normally a person under 18 years of age but for the purpose of this study including 19 year olds[16]

Children affected by AIDS: children who are living with HIV; or have lost one or both parents to AIDS; or whose survival, wellbeing or development is threatened or altered by HIV

Double orphan: a child who has lost both parents

Incapacitated adults: adults who are bed-ridden, senile or with a serious disability, and so have limited or no role in providing household leadership and care, and are partly or wholly dependent on child household members for their survival

Idir (also called Kire): a self-help association for people of a neighbourhood, which usually provides support for funeral and death-related expenses

Iqub: a form of traditional banking without interest and with a support agenda. Members deposit a fixed sum on a monthly or daily basis and take the total deposited on a rotational basis. The order is decided by casting lots and the process continues until each member recovers the total amount deposited.

Kebele (also known as an urban dwellers association): the lowest administrative unit in an urban centre and part of a sub-city

Maternal orphan: a child whose mother has died

[16] A few households in this study were headed by people who were a year older than the general definition of a child just at the time of the study hence were deemed fit to be included in the study

Paternal orphan: a child whose father has died

Tsebel: holy water, or the place where it is found, believed by Ethiopian Orthodox Christians to be endowed with miraculous healing powers after bathing or drinking

Unaccompanied child-headed household (unaccompanied child-headed family): 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 with no siblings taking care of him/ herself also falls into this category

Vulnerable children: children who are most likely to fall through the cracks of regular programmes, policies and safety nets and therefore need special attention.

CHAPTER II
FINDINGS

Unaccompanied child-headed households

An unaccompanied child-headed household is 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 with no siblings taking care of her/ himself also falls into this category.

2.1 Household establishment process

General profile

From a total of 66 unaccompanied child-headed households contacted for this study, 20 of them are headed by children of 17 years of age and 16 are headed by children of 18 years of age. Eleven percent of households are headed by children of fourteen years of age and one household is headed by a child of just nine.

From the 66 child-headed households contacted for the study, 17 are headed by a younger sibling even when there was an older sibling in the family. The child with the highest level of education and therefore the most stable employment is usually in a better position to take a leadership role, although they may not be the oldest. Other reasons may include an older sibling's disability or khat[17] addiction.

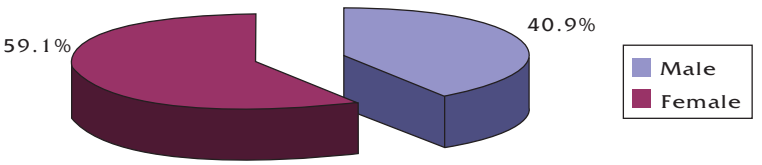
[17] A narcotic leaf that is chewed in most parts of Ethiopia

Table 3: Distribution of child household heads by age

Age	Number	Percent
9	1	1.5
10	1	1.5
11	1	1.5
12	1	1.5
13	1	1.5
14	7	10.6
15	5	7.6
16	11	16.7
17	20	30.3
18	16	24.2
19	2	3
Total	66	100

The majority – 39 households or 59 percent – are headed by girls, while 27 households, or 41 percent, are headed by boys (see Figure 3 below).

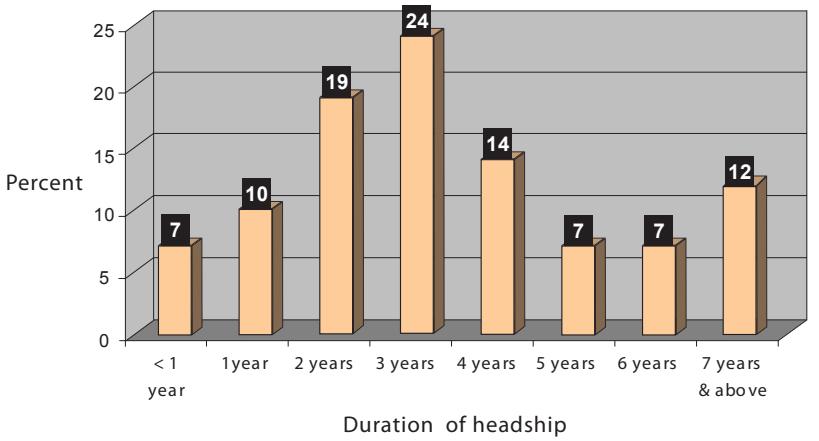
Figure 3: Distribution of child household heads by gender



The study revealed that most child-headed households were established in the last two or three years (2004/ 05), even though no census data is available for those years.

As can be seen in Figure 4, the duration of child household headship is two to four years on average, after which they leave the household, die or graduate from childhood. This points to the number of years child household heads can endure the emotional and physical stress of playing a parental role at a young age.

Figure 4: Distribution of the duration of household headship



As shown in Table 4, a third of unaccompanied child-headed households comprise three siblings, while nearly a quarter consist of one child living alone. Twelve percent of the households comprise four members; fifteen percent have two members; eleven percent have five siblings; and five percent contain six siblings.

Table 4: Household size

Size	Number	Percent
3 members	22	33
1 member	16	24
2 members	10	15
4 members	8	12
5 members	7	11
6 members	3	5

Manner of establishment

As shown in Figure 5 below, 89 percent of child-headed households were established following the death of their parents, with 12 percent established after the death of caregivers. Other reasons include the inability of parents to provide for their needs due to poverty, health problems and old age. Multiple responses were given by many child respondents, especially where parents or caregivers divorced or died.

Figure 5: Distribution of unaccompanied child-headed households by manner of establishment

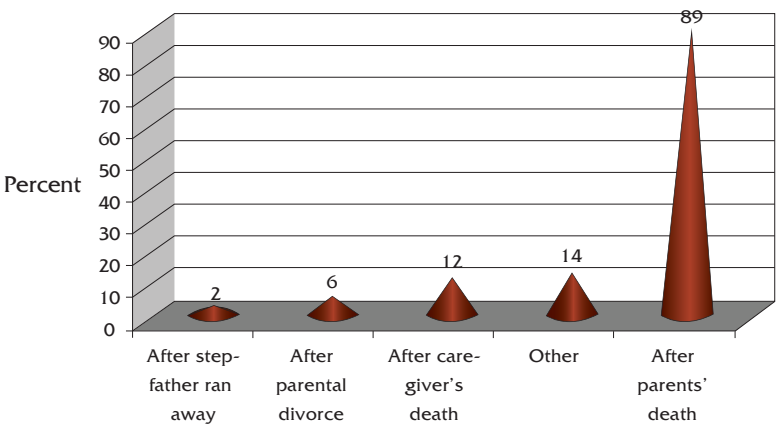
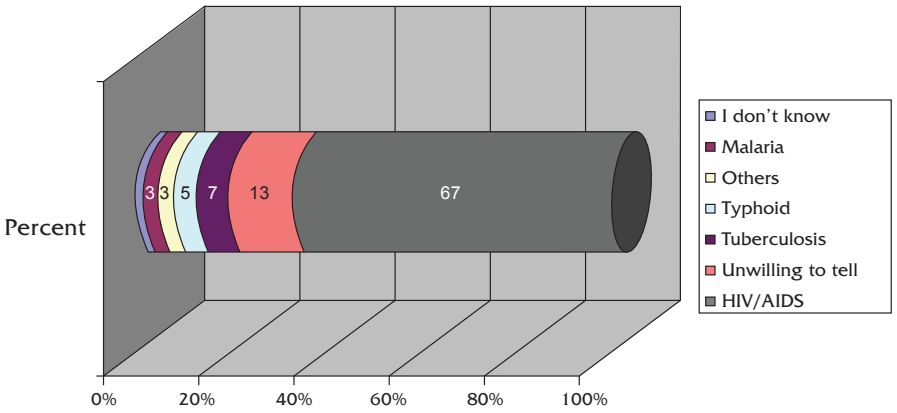


Figure 6 shows that 67 percent of child-headed households were established following the loss of parents to HIV/ AIDS, 7 percent to TB and 13 percent were unwilling to tell the cause(s).

Figure 6: Distribution of causes of parental death



Children in rural areas were found to have more involvement in the family livelihood – mainly agriculture – before their parents' sickness or death than their urban counterparts. Urban children tend to have had more time to play and study, as well as assisting their parents with small tasks such as running errands. From this perspective, the transition to a child-headed household was found to be smoother in rural areas than urban.

Very few of the child-headed households studied have relatives who offered to take them in, although a few grandparents, aunts and uncles did offer to integrate orphans into their families. Asked about why they think relatives did not make such offers, most of the respondents said that their relatives are too poor, already have large families or are too old. Some said their relatives were afraid of contracting HIV/ AIDS, which they know was the cause of parental death. One child household head said that his parents did not have a good relationship with their relatives even before their sickness and death, and that might have been the reason for the failure of his relatives to accommodate them. A few said they have no relatives at all. Even if relatives did not have the capacity to integrate orphaned children into their families, half of them come to visit the children and assist them with supplies.

Most of the children have not had the opportunity to be admitted to orphanages or childcare centres run by the government or NGOs.

There were a good number of children who would have accepted offers to be integrated into relatives' families or to be admitted into orphanages had they had the chance. However, there were also many who have been offered the chance to live with relatives and refused. As shown in Table 5 below, out of those who were given the chance to be integrated into relatives' families, 26 percent refused the offer because they feared abuse – the primary reason cited by boys – while 23 percent wanted the warmth of staying together as siblings- the main reason for girls. Ten percent of child-headed households were established to keep the promise they made to their parents before they died.

Table 5: Reasons for being established as a child-headed household among children who were offered to be integrated into relatives' families.

Reason for establishment	Number	Percent
Feared abuse in the hands of relatives	10	25.6
Wanted the warmth of being together as a family	9	23.1
Wanted to respect parents' dying wish of keeping siblings together	4	10.3
Older siblings felt they could head the family	4	10.3
Wanted to protect family property	3	7.7
Felt they would get support from NGOs	3	7.7
Felt they had the means to survive	1	2.6
Other	5	12.8
Total	39	100

Alone on the bumpy road to heading a household

Mist blankets the mountain range that forms a natural wall around the town of Dessie, as darkness descends over the town. A teenage girl sits on a torn straw mattress in a small crumbling house with plastic walls and poor lighting. Her eyes reflect sadness and deprivation, and she even appears a little deranged by her solitary life of hardship.

Bethlehem is a sixteen year-old girl heading her own household in Dessie, 400km north of Addis Ababa. Bethlehem's father died five years ago from an uncertain cause, but when his wife fell sick, she was tested for HIV and discovered she was positive. She began to take ART, but later discontinued it in favour of baptism with tsebel, or holy water, at Tsadikane Mariam, 300km south of Dessie, where thousands of people living with HIV go to hoping to experience the miraculous healing power of its waters. However, her condition worsened daily and three months into the tsebel treatment Bethlehem's mother died and was buried in Tsadikane Mariam, adding another grave to the hundreds of miracle-seekers who never made back to their home towns. Bethlehem, then aged fifteen, mourned her mother alone before returning to Dessie with the assistance of other pilgrims for her bus ticket. Now, with no relatives to turn to, she ekes out a miserable living on food handouts from her poor neighbours and a paltry income from washing clothes in other peoples' houses. "Even after I have washed piles of clothes, people take me for a beggar when they see how poorly dressed I am, and only give me a meal in return," she complains.

Inheritance of assets and debt, and succession planning

Most of the studied households inherited some form of property, goods or money from their parents, such as land, housing, cattle or furniture. However, in the majority of cases they still lack proper household facilities and materials. In some cases, facilities and services, especially those which used to be shared with neighbours, were withdrawn following the death of parents.

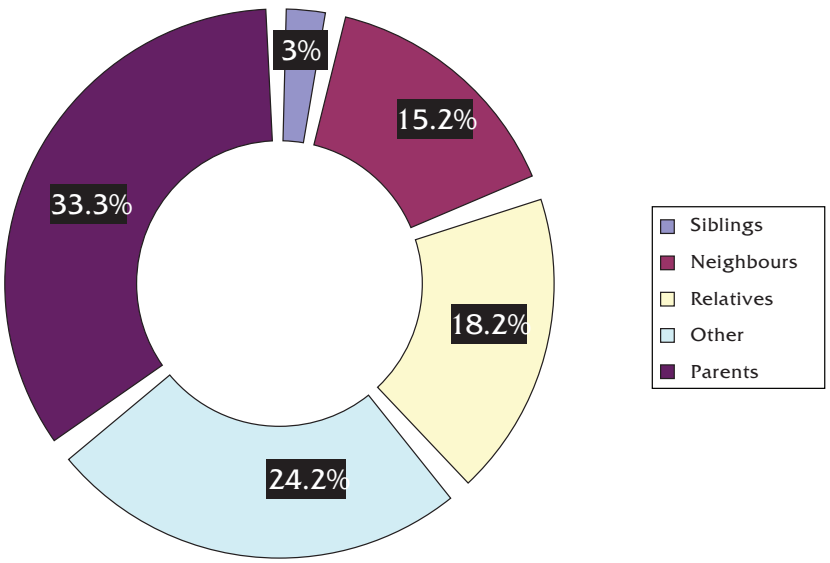
In addition to assets, some children also inherited debt. The study revealed the complete lack of proper succession planning and parent-to-child communication. Sick parents seldom communicated important monetary concerns to their children, including money borrowed or lent. In most instances, lenders came forward to claim their money, taking the children by surprise. Most of the children in this study did not expect to inherit debt from their parents, not because there was no need of money, but because they assumed money lenders would not take such risks. “There would be no one who would lend money to my parents; people knew that they would not live long enough to repay it,” said a fifteen year old girl from Dessie, who is head of a household of five after losing both parents to AIDS.

The nature of debts ranged from house rent arrears to *iqub* payments. One rural household in Modjo reported inheriting a fertiliser loan. Debt inherited by child-headed households adds yet another burden to the already stretched household budget. It can take away a substantial portion of inherited money or force children to sell off their inherited property in order to repay the debt. However, in the majority of cases, lenders took pity on the children and cancelled the debt. In very few cases, the children had to repay their debt from their paltry income. One case was reported where children were denied money owed to their deceased parents, apparently because there were no witnesses of the deal.

A large part of these problems stem from the lack of proper succession arrangements, inadequate appreciation of the importance of the situation and

lack of household financial transparency. This absence of openness can be seen from the fact that only a third of children in the study learnt the cause of illness that led to their parents' death from the parents themselves: see Figure 7. The rest heard from relatives and neighbours (18 percent and 15 percent, respectively) and nearly a quarter learnt from other sources, including hearing from hospital sources or reading the medical records themselves. A fourteen year-old girl, heading a household of herself and her sixty five year-old bedridden female relative said, "I learned about my mother's sickness when she started setting aside her feeding utensils and asked me to sleep in a separate bed." Parents' lack of openness is damaging, but it is assumed that it can be traced to a genuine desire to avoid causing despair for their children.

Figure 7: Children's source of knowledge about cause of parental illness or death



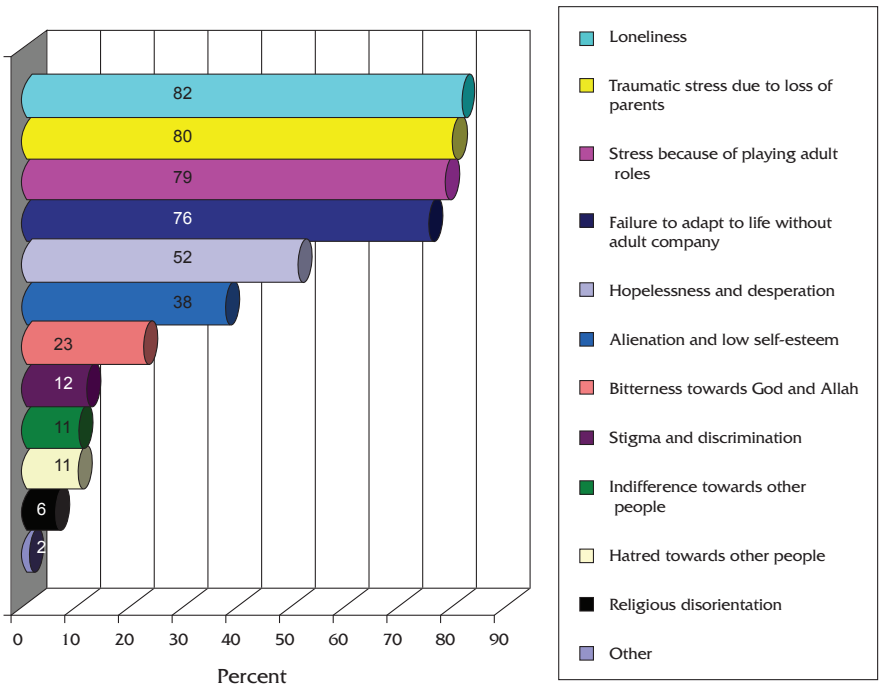
2.2 Psychological needs and challenges

"We cannot eat when our parents come to our mind. Their painful deaths and the fact that people turned their back on them torment us." A child household head in Dessie

The study revealed that child-headed households face tremendous emotional and psychological challenges, and live with the constant memory of their departed parents, who often died slowly and painfully. The children said that their memories are strongest during holiday seasons and when they see other children playing or strolling with their parents. They also recall their parents when they feel hungry, sick or when their clothes become worn out.

Most children have pictures of their parents hanging on their walls as a constant reminder of their care and love. The beds on which parents underwent their illness and other household materials they utilised also remind children of their dead parents. This painful association is one limitation of home-based care and a mitigating factor in favour of admission into an orphanage. Although orphanages have many shortcomings, emotional pain may be minimised because children do not have to live with constant reminders of their late parents.

Figure 8: Children's psychological challenges



As shown in Figure 8 above, 82 percent of the children experience loneliness, while 80 percent live with the traumatic stress associated parental loss; 79 percent live with stress associated with shouldering an adult role at a young age; and 76 percent have failed to adapt to living without adult company. The latter was slightly more pronounced among girls than among boys.

More than half of them feel hopelessness and desperation, and less than half expect better days to come when they would get proper education and employment. "I have just completed my preparatory [1st year university education] and I want to study medicine and serve my country," said an eighteen year-old girl living by herself in Addis Ababa.

Around half the child heads interviewed said that the public has a positive attitude towards them and gives them moral support, while 38 percent report low self-esteem and a sense of alienation. This affects girls more than boys, perhaps because girls

spend relatively more time at home and so have more frequent interaction with neighbours.

About 12 percent of children interviewed said that the public has an attitude of indifference towards them or blatantly discriminate against them, labelling them "ill-starred children born to cursed parents, who lost their lives to HIV/ AIDS."[18] One household head said that other children bully her younger sister by telling her about the cause of death of their parents. About half said that people look down upon them and care little for their property. There is a tendency to consider child-headed households as having no protection, and so regarding their belongings as communal property. "People would freely take away and use our household effects and utensils without even asking my consent," said a seventeen year-old girl head of a household of three siblings in Shashemane.

About 23 percent of the child-headed households in the study feel bitter towards God or Allah, and an equal percent feel a sense of indifference or hate towards other people. About half the children lay the blame for what befell their parents on God, while some accept their predicament as the result of Providence. Four households, more male than female, said they feel a sense of religious disorientation, because of the lack of adult spiritual guidance. Some said they are confused about the reasons of their plight. One head said: "I feel bitter towards God because He has taken away my parents for ever; why would I feel bitter towards people?"[19] The degree of perceived religious disorientation is more severe among boys than among girls.

Many child heads of households said that the cause of their fear and anxiety relates to the problems they have in making ends meet and the continuing survival of their households. "I feel extremely worried and nervous every month when the rent payment for our house draws close, as I have no money to pay the rent or relative to turn to," said an eighteen year-old boy living alone in Addis Ababa. A good number said that they live with fear of crime at night and rain or floods

[18] The words of a seventeen year-old girl heading a household of five after the loss of both parents to HIV/ AIDS, from the rural village of Boru, near Dessie

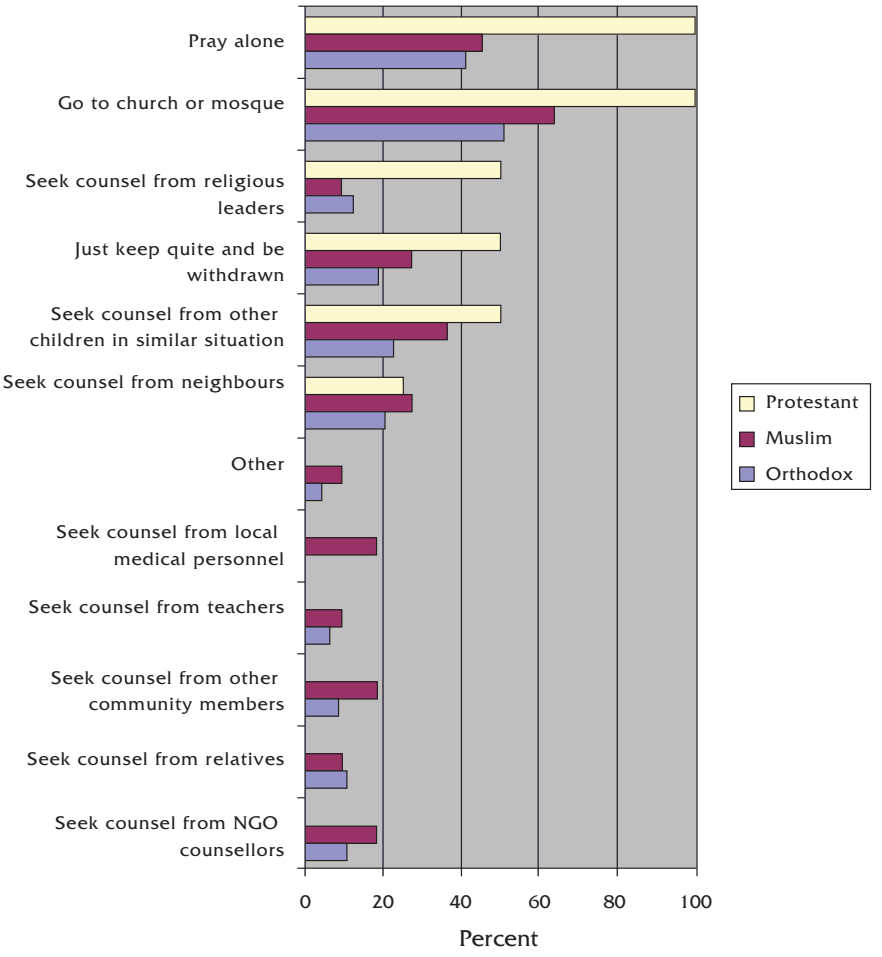
[19] Ibid.

because of their poor housing. A child head in Awassa said, “We live without adult company in a shanty area on the fringes of town always afraid of assailants .”

As shown in Figure 9 below, half the children interviewed go to church or mosque to alleviate their psychological and emotional stress, while about 46 percent choose to pray alone. Protestant and Muslim children were more likely than Orthodox Christians to go to church or mosque, pray alone or seek counsel from religious elders when they felt emotionally challenged. About 23 percent of children consider themselves emotionally withdrawn. Feelings of emotional withdrawal and seclusion were also highest among children professing the Protestant and Islamic faiths.

More children sought counsel from other children in their situation than from neighbours. Very few children sought counsel from medical personnel, perhaps because they cannot access medical services in health centres without adult company.

Figure 9: Measures children take to overcome psychological challenges



Traumatised and heart-broken

Tesfanesh, a girl of eighteen, lives in Addis Ababa with her fifteen year-old sister. Tesfanesh started heading the household in 2004 following the death of her mother. Immediately afterwards, while the girls were still mourning their mother, Tesfanesh was sexually abused by her grandfather who was living in the same house. She still lives in constant fear of him, as he vowed to kill her if she told anyone.

Following the abuse, Tesfanesh and her sister moved to another house and became established as a household by themselves. Even though other relatives live nearby, they did not come forward to take them in and have not even helped them by bringing supplies. According to Tesfanesh, this is because, "Our relatives are poor themselves, or because they know that my mother died of HIV/ AIDS." She is now employed as a cleaner in a local private company, earning a meagre monthly salary that is barely sufficient to cover two meals a day for the two sisters.

Tesfanesh still struggles to cope with her mother's death and the traumatic memory of the sexual assault by a blood relative, while being crushed by the burden of heading a household at a young age with minimal resources. Weighed down with these horrendous burdens, Tesfanesh has lost all taste for life itself and her sense of self-worth has reached rock bottom. She barely talks at all; but says, "I get temporary respite from my grief when I sit down alone and quietly shed my tears until they dampen my skirt."

This case demonstrates the serious and lasting emotional consequences of sexual abuse on girls in child-headed households and points to the urgent need for preventative measures, and legal and psychosocial support services.

2.3 Safety and security

As shown in Table 6 below, about 18 percent of children said that they are living with constant fear and sense of insecurity. Nearly three quarters of female household heads call neighbours for help, compared to 56 percent of male household heads. A higher percentage, 18 percent, of female heads of households take refuge with neighbours in times of trouble, compared to less than 4 percent of boys, which may be an indication of the higher level of trust females have in their neighbours. Two male heads of households said that they spend the night outside to look after siblings and property.

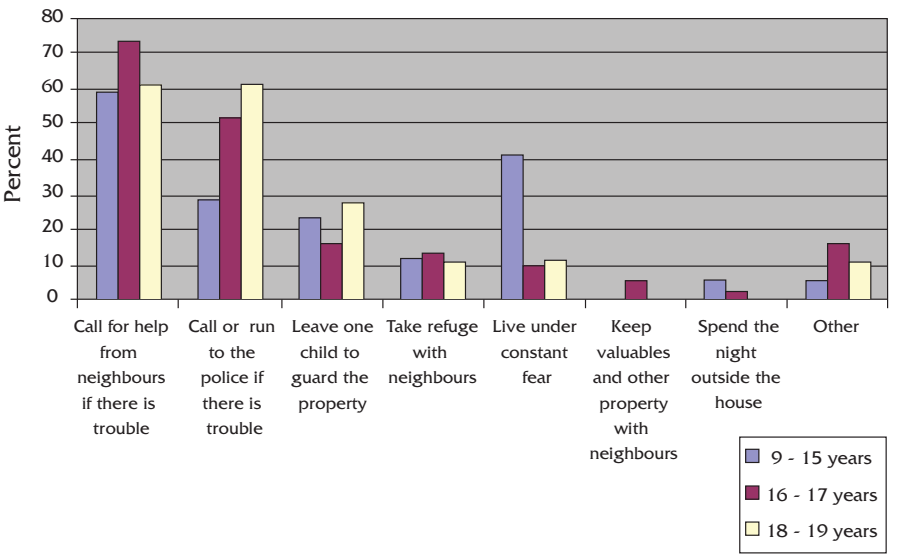
Table 6: Measures children take to satisfy security needs by gender

Measures	Male		Female		Total	
	N	P	N	P	N	P
Call for help from neighbours if there is trouble	15	55.6	29	74.4	44	66.7
Call or run to the police if there is trouble	13	48.1	19	48.7	32	48.5
Leave one child to guard the property	5	18.5	9	23.1	14	21.2
Live under constant fear	5	18.5	7	17.9	12	18.2
Take refuge with neighbours	1	3.7	7	17.9	8	12.1
Keep valuables and other property with neighbours	1	3.7	1	2.6	2	3
Spend the night outside the house	2	7.4	0	0	2	3
Other	4	14.8	4	10.3	80	12.1

* N= for Number , P= for Percent

As shown in Figure 10 below, of the child household heads who report living with constant sense of insecurity, 41 percent were from the 9 – 15 age bracket. Children in the 16 – 17 year old age bracket were found to be more likely to call neighbours for help. Older children aged 18 to 19 might be capable of facing robbers or assailants, while younger children suspect or fear their neighbours as potential assailants. This suspicion is reinforced by the children's knowledge of acts of property grabbing committed by neighbours on other children. Children in these two age brackets, namely the 9-15 and 18-19, also refrain from keeping property with their neighbours.

Figure 10: Measures children take to satisfy security needs by age



2.4 Vulnerability and resilience

The study reveals that a substantial number of girls in child-headed households have faced rape or attempted rape on numerous occasions. In one case a rape resulted in the birth of a child. Most girl heads of households spent their time on the streets, engaged in daily labour or in selling petty goods or food, making

them vulnerable to physical and sexual assaults. “I was working as a maid in the house of an unmarried man when he molested me and dishonoured me of my virginity. I couldn’t do anything other than stop working there. [20]”

Physical hazards were reported by some children, mainly attributable to their physical incapacity to carry out certain tasks. There were cases in Dessie and Shashemane where children suffered back injuries due to carrying heavy loads. In Addis Ababa, a child was badly hurt by a machine while at work and had to stay in bed for three months.

[20] These were the words of a seventeen year-old girl heading a household of her two siblings

Resolve in the face of stigma in a rural village

Semira and her family live in the village of Boru, around 10km outside Dessie, in the region of Wollo. The area has famously witnessed some of the worst droughts and famines in living memory. Semira is eighteen and currently heads a household of five children. She has been the breadwinner since 2001, when both her parents became bedridden due to HIV/ AIDS. Following the death of her parents, she took up the entire responsibility of providing for the needs of her four siblings through farming the family land. Semira has a confident and resolute manner, and an uncompromising tone of voice. Asked as to how she managed to sustain her family for so many years, including when her parents were incapacitated, her reply was firm: "I yoke the oxen myself and cultivate the land." Semira's relatives live nearby and help her with cultivation, weeding and gathering the harvest, typical of the support network in the Ethiopian countryside.

Semira sees no reason for any of her siblings to go and live with relatives; "As long as I can take care of my family, with assistance from our relatives, we will live here where the sprits of our parents dwell." By virtue of the positive role she plays in modelling the behaviour of her siblings, household responsibilities are properly shared within the family. This relieves her of some of the burden of managing the household routine; "While some of us study, the others clean the barn, collect cattle dung for fuel or herd the cattle; each child knows what he or she has to do and when."

She has demonstrated her emotional tenacity by daring to attend wedding and burial ceremonies in her village, in spite of the widespread stigma and discrimination towards children orphaned by HIV/ AIDS. "When we attend social events, people stare at us. Many people still consider us ill-starred children born to cursed parents, because they lost their lives to HIV/ AIDS, which is widely believed to be contracted because of a curse" she says.

Semira's hopes for the future are inspiring: "I want to continue my education and become a researcher, because I want to find a cure for AIDS. I want to show the community that I am a blessing, not a curse."

As in the case of Semira, most child-headed households living in rural areas were found to be leading a relatively better and more stable life than their urban counterparts. Strong social cohesion and support networks in rural areas contribute to this, as well as the fact that most rural children are used to agricultural activities even before the sickness or death of their parents. Their involvement in agricultural work is a continuation of their previous involvement in assisting the family. The other reason is that most child-headed households in rural areas inherit enough property, land and cattle to support a stable livelihood.

2.5 Property grabbing

There were reports of property grabbing in nearly all the study areas mainly committed by close relatives, ranging from snatching household property to driving children from inherited houses onto the streets. One household in Addis Ababa reported that the TV and refrigerator she had inherited from her parents were taken and sold by her relatives. Another was nearly driven out onto the streets from the kebele house she was living in when the local authorities intervened.

Some had already been dispossessed and driven out of their houses, while others were subjected to constant harassment everyday. One household in Awassa was on the verge of being driven out onto the streets by close relatives at the time this interview was conducted.

The limp arm of the law

Tadelu is a sixteen year-old girl living in Awassa, 280km south of Addis Ababa, heading her own household. She was born into a middle class family and used to live well before HIV/ AIDS snatched away both her parents. Tadelu inherited a large house full of expensive furniture, which could have been rented to raise sufficient income for her living. However, that consolation was short lived. After the customary forty days of mourning came to an end, her aunt, instead of acting as a guardian, grabbed the house and the furniture and drove her out empty-handed. As Tadelu was legally underage to bring a case, had no money to cover the cost of litigation and no immediate adult counsel at her disposal, she could not take the case to court.

Tadelu now lives in a small rented house, which takes away half of her paltry income of 100 Birr. Once an affluent girl who attended a good school and even had a private tutor, Tadelu now attends evening classes and works in the day as a domestic servant in different houses on a contractual basis. She used to own many clothes, but now relies on handouts from charitable people. The swift plunge into a life of misery has been like a bad dream for her.

2.6 Household conflict management

In looking at how child heads managed to resolve household conflicts, the study found that 72 percent of female heads of households use advice to settle differences among siblings, but less than half of males do the same; see Figure 11. Slightly more girls than boys ask for adult advice from neighbours. About a quarter of female heads of households beat their siblings for fighting, but only 4 percent of boys. There was twice as much tendency to ignore fighting siblings among female heads than their male counterparts.

Slightly more girls than boys live alone without an accompanying sibling, aggravating the vulnerability of girls to sexual and other abuse. This is exacerbated by poor and precarious housing conditions. (see section 2.9).

Figure 11: Household conflict management method by gender of child household heads

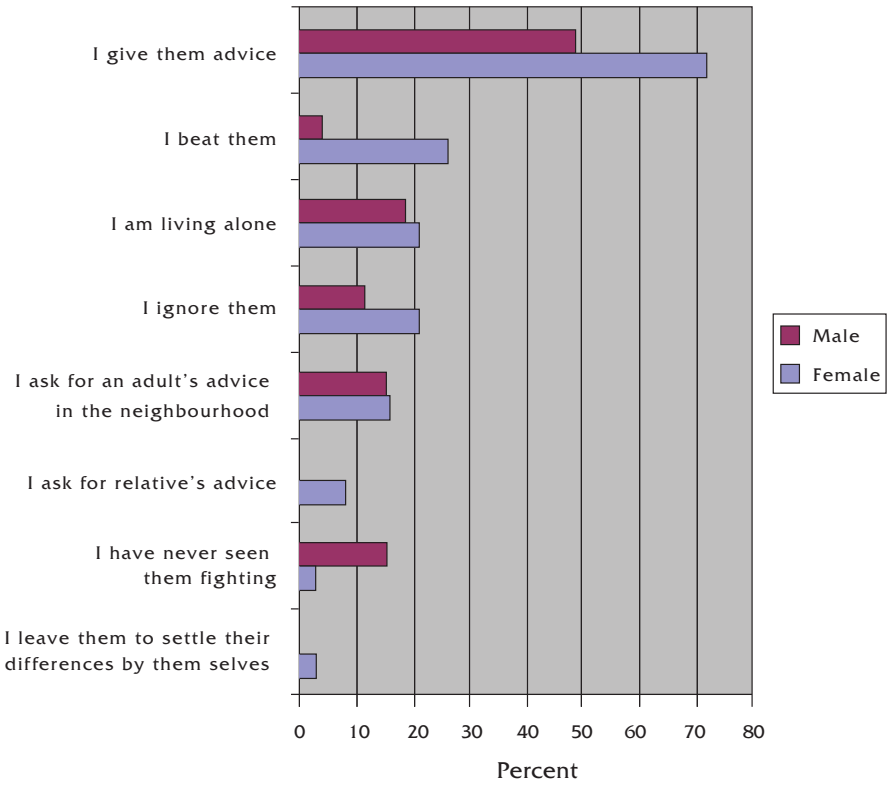
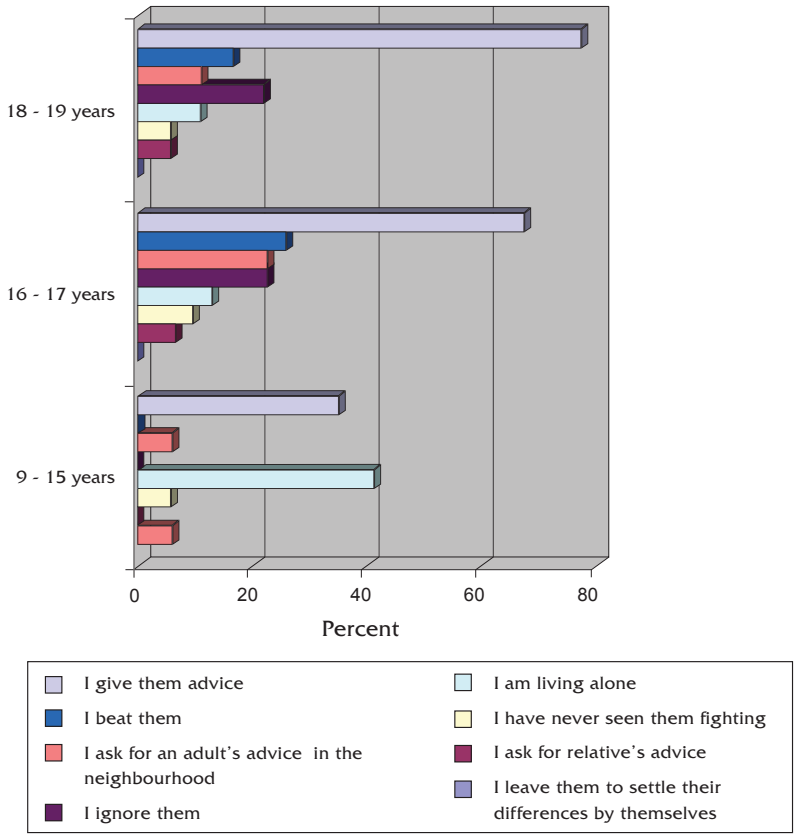


Figure 12 shows that household heads in the 18 – 19 year-old age group are more likely to give advice to siblings than children in the 9 – 15 age group. Beating is never used as a conflict resolution mechanism by heads in the younger age group, possibly due to their limited degree of authority over siblings who might be equal in stature or physical strength. Household heads aged 9 to 15 are more likely to ignore household conflict, as are females.

Twice as many household heads in the 16 – 17 age category as in the 18 – 19 age group, and around four times as many as in the 9 – 15 age group, ask for advice from a neighbour. Older children might feel more capable of taking care of their households, while the younger ones might mistrust their neighbours.

Figure 12: Method of household conflict management by age of child heads



There is a positive correlation between the educational level of the household head and their household conflict management style. Household heads educated up to secondary level opt for giving advice or seeking adult advice. However, they are also more likely to use beating as a conflict resolution method, partly because the more education they have, the older they are likely to be.

The burden of household management, including conflict resolution,has a devastating effect on child heads of households. Younger children are especially affected and complain that they lack the life skills to address the parenting and information needs of siblings. They suffer from emotional instability and identity crisis when siblings ask for arbitration or advice, and often don't know what to say or do.

Child household heads undergo psychological and physical ordeals beyond their capacity, ranging from foregoing meals for the benefit of younger siblings and treating siblings when sick, to sharing limited household supplies among the household and protecting siblings and property from assailants. Lack of experience means they are unable to fulfil the traditional parenting responsibility of teaching siblings about the ways of the world, which has serious adverse impacts on emotional and intellectual development.

2.7 Household income and expenditure

The study found that 61 percent of male and 31 percent of female heads of households are engaged in daily labour, while 13 percent of male and 9 percent of female heads are engaged in petty trading. Around 22 percent of the girls are engaged in domestic employment, mainly as maids; see Table 7 below.

Three times as many households headed by girls as boys receive aid from external sources, which may indicate the bias towards girls of existing aid systems. Twice as many girl heads of households are found to be engaged in agricultural activities, but this maybe because more girls than boys were contacted in rural areas.

Table 7: Source of income of child-headed households

Source of income	Male		Female		Total	
	N	P	N	P	N	P
Daily labour	14	60.9	10	31.3	24	43.6
Support form organisations	2	8.7	6	18.8	8	14.5
Domestic employment	1	4.3	7	21.9	8	14.5
Petty trading	3	13.0	3	9.4	6	10.9
Fishing	2	8.7	2	6.3	4	7.3
Agriculture	1	4.3	2	6.3	3	5.5
Employed in NGO offices	0	0	1	3.1	1	1.8
Engaged in mixed activities	0	0	1	3.1	1	1.8
Total	27	100	39	100	66	100

* N= for Number , P= for Percent

Most heads of households in the study areas said that they share household responsibilities and one or more siblings support them in earning a living for the household. In some cases only the head is the breadwinner, as the others are too young to work for an income or are living with a

disability, or because the child lives alone. Where there is more than one breadwinner, each usually has a say in household decision making, including budgeting. Serious household decisions with a long-lasting impact, such as selling inherited property, are made in consultation with other siblings in the household, or younger siblings are at least made aware of the decision.

Most boys in child-headed households in urban areas are engaged in daily labour, while the girls are employed as housemaids on a daily basis. The average daily income from daily labour is in the range of 6-9 Birr ($1 US is around 9 Birr), while that of housemaids is about 3 Birr. Child-headed households in rural areas get an average annual crop of six to eight quintals of agricultural produce, usually maize, sorghum and barley, which is about 3000 Birr per year based on current price estimates. This is supplemented by occasional sales of butter, honey, goats, chicken, etc. This means child-headed households in rural areas are on average better off in terms of overall income than their urban counterparts. However, rural households who don't possess land are poorer than urban child-headed households, as there are limited employment opportunities as daily labourers or housemaids.

Household chores seem to be shared more among siblings in rural areas than in urban areas. In urban areas, siblings engage mostly in petty trading or daily labour and in most cases fend for themselves, by spending much of their time on the streets. Most child heads in urban areas said that there are very few household chores to take care of. On the other hand, in rural areas the mainstay is agriculture, often on fragmented farmland, so most of the work is related to the productivity of the farm. Household chores in rural households are often an extension of farm activities, including cleaning the barn, milking the cows, feeding the cattle, etc. These factors make household responsibility sharing in rural areas indispensable.

Related to this, child-headed households in urban areas are more vulnerable to exploitation than their rural counterparts. Street life, coupled with the desperate

need for money on a daily basis to feed their siblings, aggravates their susceptibility to economic exploitation, hazardous work, forced labour and physical abuse.

Expenditure in most child-headed households revolves mainly around daily food expense. There are some monthly expenses, such as house rent, electricity and water bills, and occasional expenses are made on items like clothing.

2.8 Nutrition

Figure 13 shows that 56 percent of households engage in daily labour to satisfy their nutritional needs, while 23 percent reduce the number of meals they eat every day; 35 percent of the children often have only two meals per day, while 65 percent have three meals per day. Nearly all the children in the study said they usually eat bread with tea for breakfast and injera [21] with shiro wot [22] for lunch and dinner. [23]

A fifteen year-old girl heading a household of five children in Awassa said, "When I come home empty handed, we all go to bed without food. Especially the youngest child cries when he gets nothing to eat; he is already malnourished."

Fourteen percent of the children in the study beg neighbours for food and nine percent ask relatives for food. Around 20 percent visit food rationing NGOs and an equal percent substitute more expensive food items with cheaper ones. About 17 percent of households reduce the quantity of food per meal and the same number take food on credit. Six percent of households have sold property to buy food and three percent have stolen food from neighbours or other places. One household in Shashemane reported that they sold a bed and mattress inherited from their parents to buy food and another girl head reported she had traded sex for food.

[21] Local traditional bread and staple food

[22] Sauce made with ground peas or beans

[23] Bread with tea and injera with shiro wot are generally the cheapest meals in Ethiopia

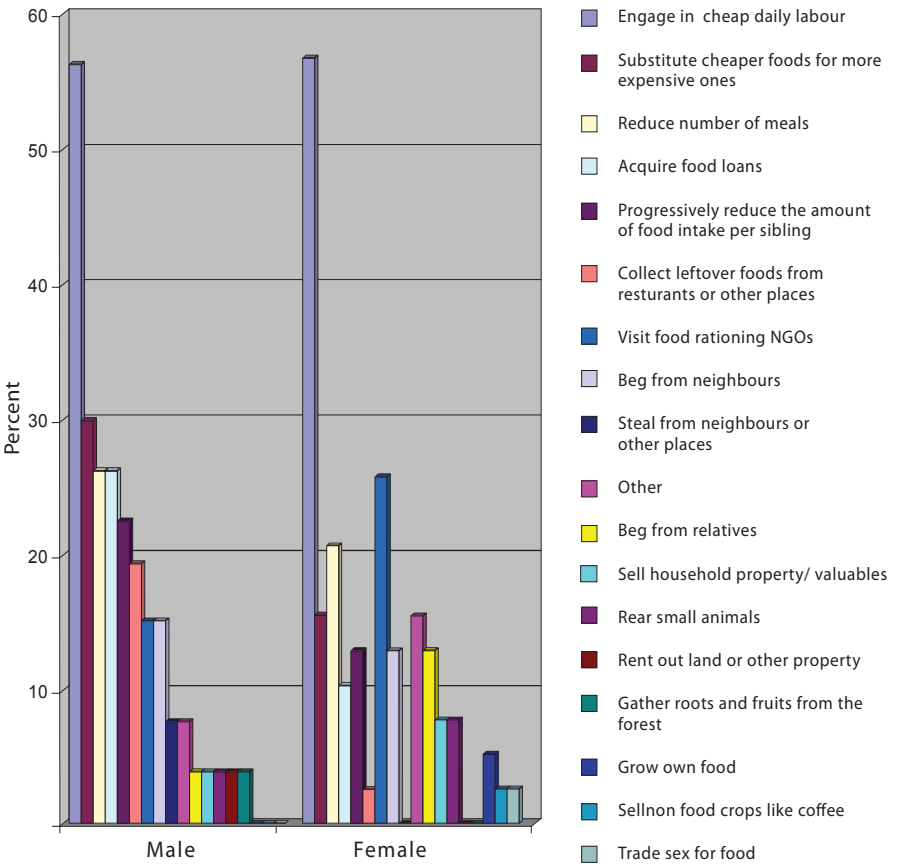
The number of girl heads of households who substitute cheaper food items for more expensive ones or reduce the number of meals per day is lower by half than the number of boys who do the same. More girls than boys have also visited food-supplying NGOs. This demonstrates the efforts girls are making to sustain meal frequency, quantity and quality, and their possibly better food management skills.

Nine percent of children in the study areas beg or collect leftover food from restaurants, rubbish bins or other places. More boys than girls collect leftover food, partly explaining why more boys than girls frequently have stomach complaints.

The combined effect of poor nutrition, poor health, and physical and psychological exhaustion arising from being overstretched is that most of the children have a diminutive stature. The younger ones look stunted and malnourished; their skinny limbs and swollen bellies show one of the costs of living without parental care.

Most children in child-headed households survive on mouldy and rotten leftover food

Figure 13: Measures children take to satisfy nutritional needs



2.9 Housing and shelter

Over 60 percent of child-headed households in the study areas live in the houses that were rented by their parents before their death, while 9 percent live in houses which are the property of their parents. As the majority of parents of child-headed households in the study died due to HIV/ AIDS, the possibility of their houses being renovated and in good condition is unlikely, partly because resources have already been depleted for medication.

Most households are unable to afford their house rent; the study found that rent arrears account for the majority of the debt inherited by children from their deceased parents. This explains why most of the children visited for this study live in dilapidated and crumbling mud houses or under plastic shelters. Most of the houses have leaking roofs, shaky doors and no glass in the windows. These conditions not only expose children to wind and rain, but also intensify their sense of insecurity at night. Until recently, one child-headed household in

The housing conditions of child-headed households exacerbate the vulnerability of girls to sexual abuse

Dessie lived under a bridge on a riverbank in precarious conditions and with the constant fear of flooding, before moving into a house rented by a local NGO.

There is a psychological dimension for children living in the same house where their parents often suffered a lingering and painful death, with a severe and continuous impact on children's emotional stability.

Table 8: Housing arrangements

Housing arrangements	Number	Percent
Rented by parents before their illness	40	60.6
Parents' property	6	9.1
Freely given by the government	1	1.5
Freely given by relatives after death of parents	2	3
Freely given by a charity organisation	1	1.5
Other (including rent after parental death)	21	31.8

2.10 Healthcare: "Keeping drugs out of the reach of children"

The study interviewed health personnel in selected health centres in the study towns to look at the medical challenges and health complaints of child-headed households. The interviews revealed that from a total of 57 medical complaints of children living in child-headed households, 21 percent were cases of diarrhoea and 13 percent were cases of pneumonia. Severe malnutrition, skin problems and stomach upsets caused by unhygienic food, housing and environment together accounted for 27 percent of the reported cases. Teenage pregnancy as a result of rape, sexual abuse and prostitution were also reported as complicating the health problems of girls in child-headed households.

The interviews with medical staff revealed that the challenges facing child-headed households in accessing public health services are four-fold:

1.Unaccompanied children find it difficult to articulate their health problems directly to doctors. Even when they do, medical staff are often reluctant to take what they say at face value for fear of potentially prescribing the wrong medication. This was found to be the case in most areas covered by the study, as lack of laboratory services makes it difficult to clinically verify the cause of illness. There is only one laboratory technician for more than 48,000 Ethiopians [24] and there are hardly any laboratory services in rural areas.

2. Related to the first challenge is the reluctance – often legitimate [25] - to supply young children with medicines and drugs. Children may not be able to comprehend the

[24] Central Statistical Agency (2007),

[25] Article 257, paragraph 1, of Ethiopian Family Law provides that the guardian shall see to the health of a minor. paragraph 2, stipulates that the guardian take measures for the re-establishment of the health of the minor in case the latter falls sick

instructions, and the potential effects of administering the medication incorrectly may be worse than the illness itself. 'Keep drugs out of the reach of children' is a basic tenet of medical safety, but it is put to the test by the emergence of the child-headed household phenomenon.

3. Children do not have information on the location of health centres and lack the experience to navigate through bureaucracy including obtaining treatment cards or letters of support from kebele authorities to prove their orphan status. Partly for these reasons, the study revealed that only 47 percent of children said that their household visits health centres to seek medical services, while 35 percent opt to pray for healing and 27 percent use traditional herbs and plants. "When sick, we use medicinal herbs and plants to alleviate the pain," said a sixteen year-old girl heading a household of five children in Addis Ababa who have lost both parents to HIV/ AIDS. The youngest brother, aged six, is suffering from tuberculosis.

4. Children orphaned by HIV/ AIDS were reported to come to health centres seeking treatment when in fact they are not sick at all. According to medical workers, these children are always alert to their health, as they expect to be hit by a deadly sickness and trace any minor sickness to the cause of their parents' death. However, most medical workers lack training and experience in providing trauma counselling and psychological support, and are not able to sufficiently reassure the children.

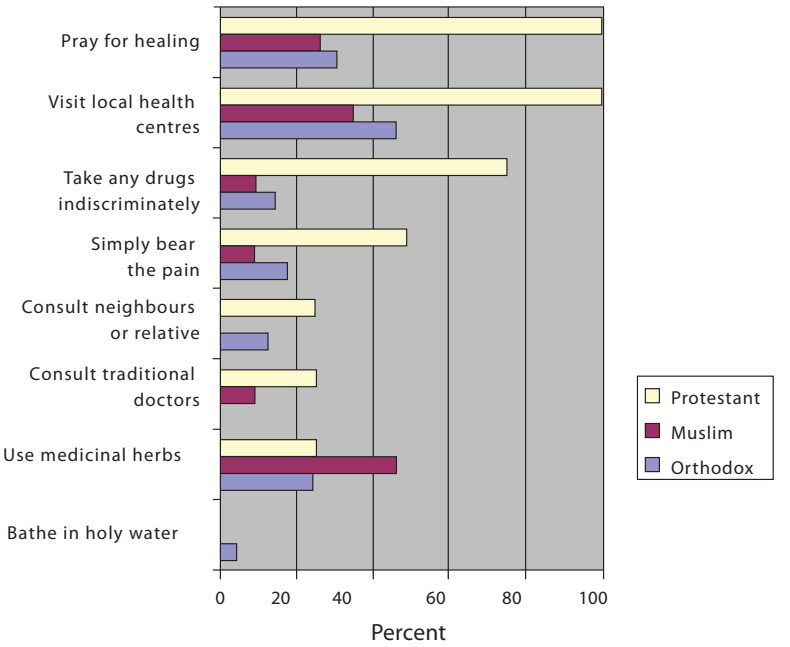
The factors given above by medical staff help to explain why 17 percent of the children interviewed said they simply bear the pain, while 12 percent of the children consult neighbours or relatives for medical advice. Another 17 percent of the children took whatever drugs they could find, [26] with potentially fatal consequences. As the majority of child-headed households in Ethiopia were established following the death of their parents from HIV/ AIDS, it is likely that

this self-medication includes taking leftover ART drugs. As ART is a very powerful treatment, this could be particularly dangerous. A sense of fatalism related to their early exposure to mortality may be another reason why child-headed households do not make efforts to access medical services.

In Ethiopia religious orientation often has a bearing on choice of medication and search for healing, as borne out by this study. As shown in Figure 14 below, all the children professing the Protestant faith pray for healing, followed by 31 percent of Orthodox children and 27 percent of Muslim. All Protestant children heading households also visit local health centres, while only half the Orthodox and 36 percent of the Moslem children do so. A small number of children professing the Orthodox faith drink or are baptised with holy water for healing, while no children of other faiths did this. Nearly twice as many Muslim children as Christians use medicinal herbs and plants. The majority of Protestants use self-medication, and the tendency to simply bear the pain was also higher among children professing this faith.

[26] This may involve taking drugs which they have seen other people taking or which they have themselves tried in the past.

Figure 14: Measures children take when sick by religion of child household heads



2.11 Parental void and the schooling of child-headed households

I have dropped out of school to take care of my siblings; I cultivate the land and gather the harvest; I go to the market to sell grain and buy supplies; I wash my siblings' clothes. They help me by fetching water, herding cattle and collecting cattle dung for fuel and my younger sister cooks food for us.

A seventeen year-old boy heading a household of five children and his blind 58 year-old grandfather.

Table 9 shows that 29 percent of child heads do not attend school because they lack money to cover school expenses, while 18 percent and 15 percent respectively, stated lack of time and scholastic materials. Eight percent do not attend school because they are too tired from working; six percent do not have

enough food to sustain them during school hours; frequent sickness leading to absenteeism was cited by five percent of children; and one child reported fear of stigma as the reason for not attending school.

Table 9: Reasons for not attending school

Reason	Number	Percent
No money to cover school expenses	19	28.8
Lack of time	12	18.2
No school materials	10	15.2
Too tired because of work	5	7.6
No proper food to stay long hours at school	4	6.1
Frequent absence due to sickness	3	4.5
Fear of the effects of possible failure at school	2	3
Need to take care of property	2	3
Fear of stigma at school	1	1.5

Although the scope of this study does not warrant a detailed discussion about the impact of the absence of adults in a household on children's academic performance, a few generalisations can be made based on the study's findings. The children interviewed who are attending school believe that lack of adult, particularly parental, follow-up, support and encouragement is the single most important factor missing in their schooling and a major contributory factor to their low scores and absenteeism. Child heads of households said that they lack the maturity and knowledge to give proper guidance to their siblings regarding education.

Interviews with teachers in selected schools showed that children from child-headed households are at a significant disadvantage. They lack educational materials and come to school on empty stomachs. Most cannot afford to pay for transport, so they have to walk long distances to and from school and arrive late and tired. They usually miss some classes as they need to work for money. In urban areas, children from child-headed households stay out late in the evening to earn a living by selling cigarettes, roasted grain, lottery tickets, etc., so they do not get enough time to sleep or do their homework. Teachers reported that

At a young age this child head of a household in Dessie dropped out of school to look after her younger brother. Her school books now hang from the wall unused

children from child-headed households have particularly low scores in maths and English, which are subjects that usually require extra study at home. Their participation in class is limited as they often fall asleep or day dream in classrooms. Participation in extra-curricular activities is non-existent, and they frequently miss exams. Repeated low scores lead to a sense of failure and, coupled with lack of parental consolation, are a catalyst for dropping out of school altogether. The problems facing these children can all be traced to the absence of adult support. “I see a huge difference in academic success between children who learn with the support of parents and without them,” said a teacher in a small village in southern Ethiopia.

Where going to school is a luxury

A short distance from a luxury restaurant in the fast developing town of Awassa, one could see a group of children who carried shoe paint boxes almost their size. These children who make a living by shining shoes often huddle together as do certain variety of small fish in shark infested waters. And one may wonder if the clustering of these little children is their shield in the face of potentially abusive customers.

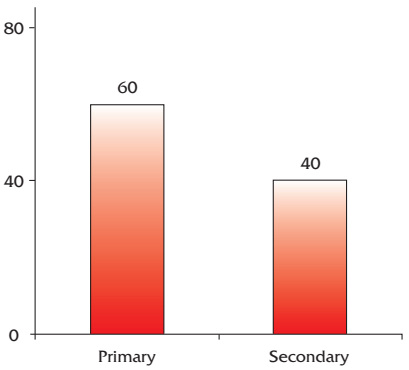
Among these children is Lebu, a member of a household headed by his sixteen year-old brother, Gezu.

Gezu, Lebu and their sister Marta used to lead an average life before they lost both their father and their mother in rapid succession to HIV/ AIDS. Their lives changed abruptly, as they had to learn to fend for themselves with no known relatives to help them. With limited skills to earn a living, they had to resort to the readily available option of self-employment in the informal sector. Gezu became a daily labourer, while Lebu joined the army of shoe-shining boys. Both earn income under exploitative circumstances and spend a good part of their time on the streets. They are vulnerable to physical

abuse by customers who deny them of payment. Even if they had a strong interest in learning before, education has now become a luxury to them, when their preoccupation is where the next meal will come from.

As Figure 15 shows, educational attainment is low among child-headed households. Sixty percent of child household heads have attained only primary level (Grades 1 to 8), while 40 percent have attained secondary level (Grades 9 and above). This has important implications for their capacity to manage a household, earn money and provide educational guidance, as well as health and nutritional care, to their siblings. From the 66 child household heads contacted for the study, 49 are over sixteen, hence old enough to have attained secondary level education. The fact that most of them have not progressed to secondary level is an indication of the high rate of school drop-out among these children.

Figure 15: Distribution of unaccompanied child household heads by level of education



Studies conducted elsewhere show that good academic results are more likely where parents are involved in reading with their children, support them with homework assignments, provide encouragement, arrange for appropriate study time and space, monitor homework and/or actively

tutor their children. [27] Studies also showed that there are strong positive effects of parental involvement on student outcomes that exceed achievement. These include attitude toward school or toward particular subject areas, improved self-esteem, classroom behaviour, time spent on homework, expectations for the future, reduced absenteeism, motivation and retention. [28]

Parents can support their children's schooling by attending school functions and reflecting children's concerns through attending parent-teacher conferences. With no parents or guardians to speak for them, the academic needs and challenges of child-headed households remain unrepresented.

Ethiopia has recently eliminated the morning and afternoon shift system of its schools without bearing in mind the needs of child-headed households. Many used to work for half a day and attend school for the other half, but with no shift system they often have no choice but to drop out of school altogether.

[27] Cotton & Wikelund (2001)

[28] Ibid.

Due to their dire situation, children from child-headed households may not be able to respect school norms. Coupled with the stigma of their parents' death or illness, this may alienate them from their teachers and peers. It is common in Ethiopian schools to ask children who are frequently late, absent or who do not do their homework to bring their parents to school to explain. Teachers are not always aware when children come from child-headed households, so they sometimes expel the children from class when they fail to bring their parents to school. All these issues further compound the children's sense of depression, alienation, emotional instability, low self-image and pessimism.

As well as missing out on parental support, children in child-headed households also lack teacher and peer support for the above reasons, further damaging their chances of educational success. Teachers and school administrators need to assume a surrogate parental role to fill the void left by bedridden or deceased parents.

2.12 Sanitation and bedding

The study found that child-headed households have serious problems with sanitation materials and facilities, which particularly affects girls. As Table 10 shows, 48 percent of boys and 36 percent of girls use public toilets, while 13 percent of girls and 22 percent of boys use bushes to excrete. The fact that some girls use bushes in spite of their vulnerability to sexual abuse is an indication of their desperate situation. On the other hand, more girls than boys visit toilets in the neighbourhood. One girl reported using leaves for lack of menstrual pads. Two girls and a boy reported utilising herbs and leaves instead of soap for washing clothes and bathing.

Table 10: Measures children take to satisfy sanitary and bedding needs by gender

Measures	Male		Female		Total	
	N	P	N	P	N	P
Visit public toilets	13	48.1	14	35.9	27	40.9
Make simple beds and mattresses from sacks and straw	14	51.9	13	33.3	27	40.9
Visit pit latrines in the neighbourhood	4	14.8	13	33.3	17	25.8
Dig own pit latrines near the house	2	7.4	7	17.9	9	13.6
Visit the bushes to excrete	6	22.2	5	12.8	11	16.7
Receive sanitary materials for free from NGOs	3	11.1	5	12.8	8	12.1
Use potties	1	3.7	4	10.3	5	7.6
Use natural materials instead of soap	1	3.7	2	5.1	3	4.5
Ask neighbours and relatives for sanitary materials	1	3.7	2	5.1	3	4.5
Use leaves instead of tissue paper or menstural pads	1	3.7	1	2.6	2	3
Other	5	18.5	4	10.3	9	13.6

* N= for Number , P= for Percent

2.13 Social and recreational activities

The majority of the child heads of households interviewed said that they have no money or time to attend social events, such as burial and wedding ceremonies, even if they wanted to. A few said they attend such ceremonies and are warmly welcomed by the people. Some reported that they are never invited to such events, because they are too young or are new to their current area.

Nearly all those contacted said they have little or no time to play, and if they

do have time, they feel more comfortable playing with their own siblings than with other children. Most of the child heads of households said that they have to work from dawn to dusk to earn a living for themselves and their siblings. A good number of the children said that they lack interest in playing for reasons they did not understand. One household head said that she faces discrimination while playing. Most children who receive NGO support, so do not have to work to earn a living, said they play freely with others.

"Our joy is buried along with our parents"

Abegaz is an eighteen year-old boy heading a household of six children in the town of Dessie. He has been the virtual head of the household since 2001, when both parents became bedridden due to HIV/ AIDS. Following the successive death of their parents, Abegaz had to become the actual head of the household. He works as an assistant mason, which means he has to carry heavy slabs of stone from dawn to dusk, mostly on an empty stomach. His younger sister converts money into coins for telephone users and taxis, while his younger brother sells plastic bags.

Abegaz has no friends and has virtually lost any desire to enjoy himself. A traumatic past and a miserable life, worsened by the awesome burden of heading a large household for seven years, have dulled his youthful sense of pleasure; "our sense of joy has died and is buried along with our parents," he says. Abegaz wears an oversize coat inherited from his father, contributing to his serious and adult demeanour. "We feel sad when we think of the agonising lingering death of our parents. We had no relatives to stand by our side; we were the only ones to take care of them. People still call us ill-fated children, because we lost our parents to HIV/ AIDS." His concluding words sound an urgent alarm: "We are forgotten by everybody. We need support before we die; dead people need no aid."

Child-headed households accompanied by incapacitated adults

A child-headed household accompanied by incapacitated adults is run by a child who provides the household income and takes care of the household with other younger siblings. The parents or primary caregivers are usually incapacitated through chronic illness, such as HIV/ AIDS.

2.14 General profile

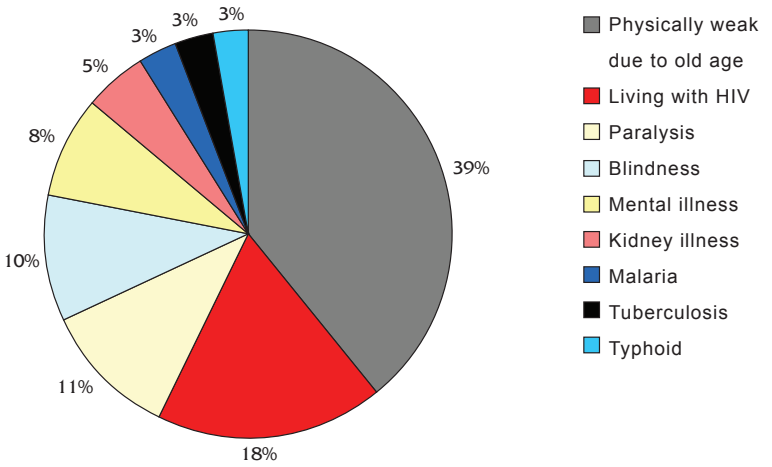
As shown in Table 11, more girls than boys are child heads of households that are accompanied by adults, as is the case for unaccompanied households. Slightly more boys than girls remain household heads for a longer time, as girls get married earlier.

Table 11: Child-headed households by gender of head

Gender	Number	Percent
Male	21	48.8
Female	22	51.2
Total	43	100.0

Accompanied and unaccompanied child-headed households are similar in terms of their basic needs and the measures they take to satisfy them. However, the presence of incapacitated adults in accompanied child-headed households adds a new dimension of challenges related to the special needs of adults. Accompanied child household heads have to cater for the material, medical and emotional needs of incapacitated adults, in addition to the needs of siblings.

Figure 16: Cause of incapacity of adult household members

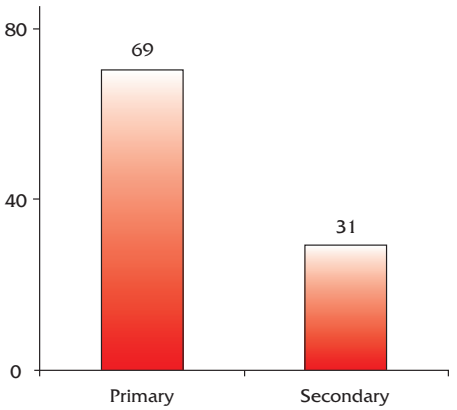


As shown in Figure 16, 39 percent of adult household members are physically weak due to old age, while 18 percent are incapacitated due to HIV/ AIDS. Eleven percent are living with some kind of physical paralysis. Therefore, adult support in the form of physical labour is largely missing in most accompanied child-headed households. Eight percent of the incapacitated adults suffer from mental illness, which indicates the complexity of the burden of care and support child household heads have to shoulder.

More children in households with incapacitated adults take part in funeral ceremonies and idir gatherings than those from households comprising only of children. These are critical social commitments that are never missed by most adult Ethiopians. Idir gatherings are held to express condolences to people bereaved of family members and relatives. Often money is handed over as an expression of compassion and care. Failure of idir members to regularly attend events could trigger serious disrepute in the community, to the point where members could be left without burial grounds. Participation in idir and funeral ceremonies is thus an important concern for a bedridden adult, and yet another adult role delegated to child household heads.

Figure 17 below shows that 69 percent of children heading households with incapacitated adults have attained only primary level education. This has implications for children providing for the emotional and healthcare needs of bedridden adults. For example, children who have only been educated to primary level may have difficulty in reading medical prescriptions or understanding hours of drug intakes. Unaccompanied child-headed households have better educational attainment: 40 percent of them have attained secondary level compared to only 31 percent of accompanied child heads, demonstrating the relatively heavier burden laid on the latter.

Figure 17: Distribution of accompanied child household heads by level of education



2.15 Challenges

Children heading households including incapacitated adults face different challenges than their counterparts heading households composed only of children. Adults are often unsatisfied with the food prepared by children and the care they provide, and can easily become frustrated at being dependent on a child for their survival. In other instances, adults disregard the advice of child household heads. One household head said she could not convince her bedridden father, who is on ART, to stop smoking cigarettes, and that he would smoke in her absence when she went to school or to the market.

Accompanied child-headed households face serious problems in accessing money, especially for supplies and medical needs of the bedridden adults in the household. Most are physically too weak to move the bedridden adults in their care, which is a cause for frustration for both the adults and the children. “My little sister and I share household roles and responsibilities, but we face difficulties when our bedridden mother asks us to move her onto the bed. We are just little children and physically too weak to do that,” said Henok, a fourteen year-old head of a household, caring for his forty year-old bedridden mother and nine year-old sister in Addis Ababa. An eighteen year-old heading a household of four members, including her fifty year-old mother living with HIV, reported having to carry her mother on her back to the clinic whenever she has a medical appointment. Sick adults living with HIV often have to take ART without food or with only a nominal meal, compromising the drug’s effectiveness.

Poverty and Anti Retroviral Therapy

Yeshimebet and her mother share a meal of injera sprinkled with berbere[29] on a table crowded with tin cans, used for selling traditional alcohol. Berbere is an essential ingredient in Ethiopian cuisine, but no one would eat it as a sauce in it own right unless they were really desperate. The packet of medicine on the bench is a clue to the nature of the desperation; the packet is ART drugs and Yeshimabet's mother is HIV-positive.

Eighteen year-old Yeshimebet and her mother live in the town of Shashemane, 250km south of Addis Ababa. Yeshimebet's father died three years ago and her mother has been bedridden since then. Yeshimebet earns a paltry income by carrying out domestic chores, such as washing clothes, cooking and cleaning, in different peoples' houses.

The household is living in an

[29] Hot red pepper, dried and ground into powder

abject state of poverty. Benches covered with dried goat skin are used as beds. The walls of the house are crumbling and the cramped interior is in a deplorable state; miscellaneous household materials are dumped in an unhygienic heap.

Yeshimebet does go to school, but because she spends a good part of her time working for a living and caring for her mother, she is frequently absent from school and has hardly any time to study. Therefore, her results are very discouraging and she sees little prospects for future improvement. The poignant mixture of poverty and disease has made life unbearable for this household that consists of a child and her bedridden mother. The mother mostly takes ART drugs without eating, thus reducing the effectiveness of the drugs and her chance for an improved standard of health.

Table 12: Measures taken to satisfy educational needs

	Male		Female	
Measures	N	P	N	P
Engage in daily labour to raise money for schooling	10	47.6	13	59.1
Resort to low cost and flexible educational services	7	33.3	4	18.2
Engage in hazardous and difficult work	4	19	2	9.1
Ask neighbours or relatives for help	2	9.5	0	0
Attend only a few days and work the rest	2	9.5	4	18.2
Beg school authorities for help	1	4.8	4	18.2
Opt for private study at home	0	0	1	4.5
Trade sex for schooling of myself and my siblings	0	0	1	4.5
Other (including NGO support)	6	28.6	2	9.1

* N= for Number , P= for Percent

As most of the child household heads work as daily labourers, they are forced to leave behind their sick parents without anyone to attend to their needs (see Table 12). At home, many children have to stay awake at night to tend to their parents who struggle with pain. Some leave their sick parents behind when they go to school, but once at school, they report experiencing a lack of concentration as they think about their sick parents at home. Therefore, these children frequently abstain from school and score lower grades. In order to gain time to care for bedridden parents, 18 percent of the children use low cost and flexible educational services, such as Priest or Koran schools.

Children in accompanied child-headed households have to care for sick parents without taking necessary safety precautions for themselves. They are not only responsible for preparing food for their sick parents and siblings and washing their clothes, but also for taking their sick parents to hospital and buying the prescribed drugs. Through lack of choice, they are also often entirely responsible for monitoring the hours and doses of drug intakes, mostly ART, without the maturity or education to grasp the scrupulous regime involved in the usage of the drugs. In households where there are terminally ill parents, and therefore virtually no adult supervision, the problem of children self-medicating is on a par with unaccompanied child-headed households.

Reversed roles and stressed souls

Biritu is fourteen and lives in the village of Shera, 25km outside the town of Modjo. She heads a family of three children and her forty year-old mother, who is HIV-positive, in a shelter provided by a benevolent person. The household survives on a monthly handout of 45kg of wheat from a local NGO, supplemented by the daily income of 3 Birr that Biritu earns by collecting and selling cattle dung for fuel. In this situation, with five mouths to feed, three meals a day are a luxury. Biritu's mother has recently become paralysed from the hip down and can hardly move, so Biritu always has to be around. She is regularly absent from school and has little time to study.

The most worrying aspect of life for this child household head is the psychological and physical burden of care for her bedridden mother. Biritu has to carry her mother on her back to the local health post whenever her mother feels pain.

She also bathes her mother and has to remove her excreta with unprotected hands. “I have no gloves, so I fear contracting HIV. Even without gloves for protection, I have to do it, as I am the only one old enough to care for our mother,” said Biritu.

Monitoring her mother’s drug intake is a constant preoccupation. There is no clock in the house, so this overstretched girl has to rely on nature to tell the correct times for her mother’s ART drug intake, by looking at the position of the sun. The rigorous precision of timing demanded by these drugs is left to the elements.

In child-headed households with accompanying adults, the delicate responsibility of emotional care and counselling for sick adults rests entirely on emotionally immature and strained children. This task is all the more challenging because most adults live with a sense of regret about their past and are extremely anxious about the future of their children. “Our mother seemed to always be troubled about our future. She would often call me to her bedside and say, ‘be a strong girl and take care of yourself.’ I didn’t realise at the time that she knew her death was imminent. That was the most agonising part of her ordeal,” said a seventeen year-old girl heading a household of three children who have lost both parents to HIV/ AIDS.

Nearly ninety percent of children heading households that included incapacitated adults reported suffering from stress due to the adult roles they have to play, including caring for bedridden parents. The role reversal that has been forced upon these children is taking a dreadful toll on their emotional development.

Both categories of child-headed households have severe problems of food, shelter, clothing and other basic needs. Problems of shelter were found to be more severe for child-headed households containing incapacitated adults, especially those living with HIV, mainly due to the stigma and discrimination associated with the virus.

Table 13: Psychological challenges faced by accompanied child-headed households

Psychological Challange	Number	Percent
Stress of playing an adult role, including caring for bedridden parents	38	88.4
Hopelessness and desperation	9	20.9
Bitterness towards God or Allah	8	18.6
Alienation and low self-esteem	6	14
Stigma and discrimination	3	7
Indifference towards other people	3	7
Religious disorientation	2	4.7
Hatred towards other people	1	2.3

Always on the move

Tsion is a seventeen year-old head of a household in the town of Modjo, 73km south of Addis Ababa. Modjo is located on a busy highway that links the populous regions of Oromia and SNNP, so it has one of Ethiopia's fastest growing rates of HIV/ AIDS.

Tsion has been caring for her bedridden father, a former soldier and veteran of the Ethio-Eritrean war, since he fell ill with HIV/ AIDS in 2005. She has been doing her best to satisfy both their needs on her father's pension of 200 Birr a month plus a 45kg monthly wheat handout from a local NGO. Life is miserable for this child head of a household, complicated by the delicacy of caring for an HIV-infected adult without sufficient income. The problem of housing has especially become their critical concern. Some time ago, they were precipitously driven out of their last rented house by the landlady, who had threatened to expel them many times before. Through kneeling down at the landlady's feet and tearfully begging for mercy, Tsion had previously managed to avert the threat. However, one day the owner carried out her threat and

threw their few belongings into the road while shouting and cursing Tsion and her father. And they had to move into a new rented house for the third time. Tsion's father, with tears rolling down his bony cheeks, says, "We are always on the move. Today we are here in this house, but only God knows where we will be tomorrow."

“The rain is my enemy”

Solomon is an eleven year-old double orphan who is now responsible for his own livelihood and that of his grandmother. Their home is a plastic shelter put up by churchgoers who frequent the Modjo Medhanealem church. The rain leaks through the roof onto their beds and their meals mainly consist of mouldy injera and dried meat, leftovers from nearby restaurants or handouts from churchgoers.

Solomon, now a second grader, attends school for half the day, thanks to support from the church. He spends the rest of the day in the street selling sugarcane, boiled potatoes and tissues. Since the rainy season set in, Solomon has been going to school late in the morning, as he has to lay out his bed sheets and other belongings to dry in the sun. Thieves recently stole his threadbare blanket and since then he sleeps wearing his school uniform. During the course of the interview, Solomon looked very anxious about where he was going to sleep that night, as his bed was covered in water. He was desperate for a bed and a blanket during the cold rainy season: “I am not afraid of anything except two things: night time assailants and the rain.”

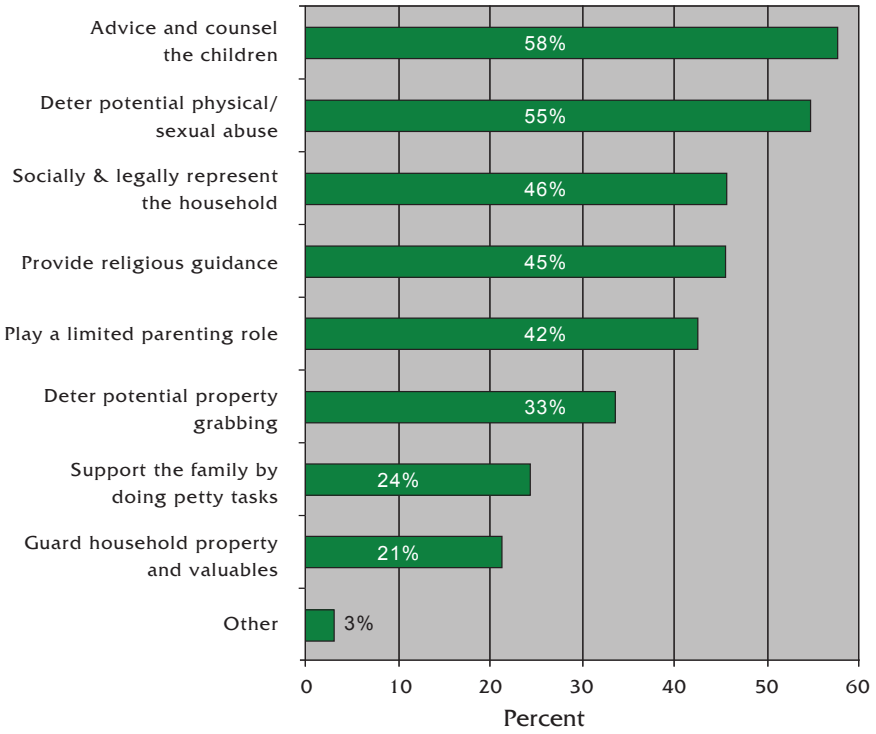
2.16 Comparative advantages

Children living with incapacitated adults have certain critical advantages over children heading households comprising only of children. Figure 18 shows that 58 percent of incapacitated adults play a role in advising or counselling children on a variety of issues, while 55 percent deter physical or sexual abuse by unscrupulous people. “I advise [the children] to learn attentively, to keep away from harmful pastimes and not to stay out late in the evening,” said a 77 year-old member of a child-headed household in Addis Ababa.

Around 46 percent of the adults are able to represent child-headed households in legal and social issues and in accessing aid, and 45 percent play a role in providing spiritual guidance and religious orientation to siblings. This confirms the finding discussed in an earlier section of this report, that more children in unaccompanied child-headed households than in accompanied households feel a sense of religious disorientation.

Forty two percent of incapacitated adults played a limited parenting role in caring for sick siblings as well as in giving educational support. In numerous cases, adults in child-headed households become involved in coordinating household roles and giving orders where the child head has not done so.

Figure 18: Role of incapacitated adults



Children appreciate the warmth brought by the presence of adults in their family, and their presence also plays a role in deterring potential property and land grabbing.

Incapacitated adult members of child-headed households play a formidable role in keeping children together and stopping them making their separate ways onto the streets; they act like glue for family cohesion.

Only 14 percent of children in accompanied child-headed households face a sense of alienation and low-self esteem, compared with 38 percent of children in unaccompanied child-headed households.

As shown in Figure 19, only about 5 percent of accompanied child household heads use beating as a conflict resolution method, compared to 17 percent of their counterparts in households consisting only of children. The presence of parents,

even if they are incapacitated, plays a role in deterring the use of force by child household heads. About a quarter of child household heads still rely on their sick parents to settle conflicts among siblings, while about 54 percent of the child heads ask for a relative's advice. In a sharp contrast, less than 5 percent of children in unaccompanied child-headed households ask for a relative's advice to resolve household conflicts. This demonstrates that the presence of parents, even if sick, plays a role in attracting relatives' support, whether in the form of advice or material provisions. One household head said that their relatives would not bring them any supplies if their grandfather was not living with them.

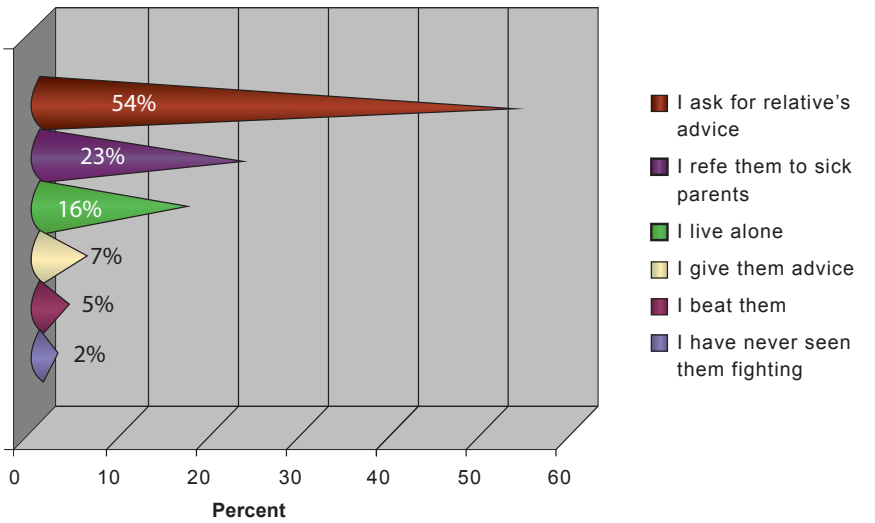
Adult members of child-headed households make important contributions in solving problems and imparting life skills to their children, and sharing their expertise with child household heads. "Our grandfather advises us on the kinds of grain to sow and when to sow them," said an eighteen year-old

"Even if she looks pale and frail due to the illness, we take delight when we see our mother present in our midst. She is the light of our home. Is there anyone who desires to live without light?"

Abebech, sixteen year-old head of a household caring for a seven year-old sibling and her mother living with HIV/ AIDS, Addis Ababa

boy heading a household of five, including his 70 year-old grandfather, in a rural household. There were also no reported cases of self-medication in child-headed households where there are adults.

Figure 19: Household conflict management style of child household heads in accompanied child-headed households



Some adult members make financial contributions, albeit small, to child-headed households: 42 percent of adult household members contributed some amount of money. Twenty seven percent of those making financial contributions obtain their income from NGO support, while eighteen percent earn an income from retirement benefits.

External help and support for accompanied and unaccompanied child-headed households

Child-headed households are a special group, even within the category of orphans and vulnerable children, with their own unique needs and challenges. Due to their limited physical and emotional maturity, child-headed households find it hard to earn a satisfactory living with no extended family network to fall back on. They need urgent material support, and, although it is limited, the majority of child-headed households in Ethiopia do receive some form of material aid. NGOs provide the most support, in the form of food, clothing, shelter and educational materials, healthcare, bedding, sanitary materials, legal protection and counselling. Educational support ranges from covering school tuition fees to buying school uniforms and educational materials. A few of the older children have been given vocational training opportunities by NGOs, towards self-sustaining employment. This is a laudable effort despite its limited coverage. NGOs are also active in providing free legal services for children who are victims of property grabbing and abuse. Such services also involve psychosocial and trauma counselling, as well as verbal advice on legal issues.

Relatives, neighbours and friends follow NGOs in the level of support provided, through clothing, food and shelter. Neighbours were also found to play a role in providing parenting and household labour support, whereas friends provide moral support.

Unlike unaccompanied child-headed households, where there is no direct government support, in accompanied child-headed households bedridden adults, especially those living with HIV, receive free ART drugs and food aid. This is one of the most laudable efforts made in recent years to improve the healthcare of Ethiopians.

There appears to be an overlap in the kind of support these children are receiving in certain areas, to the detriment of other areas. Mentoring, parenting support and skills training are almost totally missing, while food aid stands out as

the most prevalent form of aid received. There has also been limited support in the form of clothing, shelter and sanitary materials for these households.

An NGO close to peoples' hearts

Mekdim Ethiopia National Association was established in 1997 by people living with HIV. Since then, it has scored considerable success in advocating for universal access to ART, home-based care and support, and counselling and awareness creation in the face of stigma and discrimination towards people living with HIV.

"Parents dying of AIDS often call us into their houses and make their last wishes in our presence. One of the first things they do is entrust their soon-to-be orphans into our hands. Many bereaved children who happen to know their parents' connection with Mekdim come directly to us and ask for food and shelter. Adults and children alike consider Mekdim as a more trustworthy helper than a relative or a neighbour. Such kind of popular trust is incredible. However, given the current situation of dire resource shortages we are suffering, public confidence becomes an awesome responsibility that cannot be delivered and we feel emotionally overwhelmed." These are the words of a nurse and counsellor at the Dessie branch of Mekdim Ethiopia National Association. He continues, "Even if we have a strong will, we lack the resources. Every time we send children away to the streets or to their homes empty-handed, part of us goes with them and part of us is dying. We are devastated."

Free legal services for orphans and vulnerable children

Children in Ethiopia are increasingly facing abuse and neglect on the streets, in their communities and in their homes. The abuse is not only carried out by strangers, but also by the very people who are meant to protect them – their family and friends. In these cases, children often have nowhere to turn. The high cost of litigation and fear of endangering links with the community mean that abuse and neglect are often left unchecked. In 2005, The African Child Policy Forum responded to this dire need by establishing the Children's Legal Protection Centre (CLPC) in Addis Ababa, Ethiopia, the only one of its kind in the country. For the first time, children whose rights are violated, either as victims or perpetrators of a criminal offence, now have the opportunity to obtain free legal advice and representation in court. Children who are abused by caregivers or other community members are given free legal counselling and judicial representation. CLPC gives legal advice to children and their families, and prepares pleadings, legal submissions or affidavits on behalf of children. It serves all children without discrimination, but gives special attention to abused children, orphans and vulnerable children, child-headed households, street children, and children in conflict with the law.

A number of legal cases have been won on behalf of children, which is believed to have deterred further abuse and exploitation of orphans by unscrupulous relatives, caregivers, security forces and other community members.

Chapter III

An urgent alarm sounds in every page of this study report about the special support child-headed households in Ethiopia desperately need. Policy makers, advocacy groups and NGOs are urged to exert their efforts to rescue these children from the ordeals they are now undergoing.

The plight of child-headed households is alarming and unprecedented. The dreams and aspirations for a better future of children in child-headed households are being crushed under the weighty burden of psychological and economic challenges.

Due to their youth and limited skills, child-headed households earn very little by way of income, and even the little income they earn, often under hazardous and exploitative circumstances, is spent unwisely because of their lack of household management experience. On top of these responsibilities, child heads

of households have to play the role of parents in caring for younger siblings and providing them with educational and other guidance. The majority of child-headed households are victims of sexual and physical abuse, and property grabbing. Children in such households suffer from loneliness and traumatic stress due to loss of their parents. Child-headed households accompanied by incapacitated adults have to shoulder a different and complex burden. They have to take care of bedridden parents, supply their medical and sanitation needs and even monitor their drug intake. In these difficult circumstances, child-headed households need urgent support in the following areas:

Aid coordination

There is an overlap in the kind of support these children are receiving in certain areas to the detriment of other areas. There is a need to coordinate aid efforts to avoid both overlaps and gaps.

Material aid

Child-headed households need urgent material support, in the form of food, clothing, shelter, education, medical needs, etc. Especially those accompanied by incapacitated adults need such apparently mundane materials as clocks and sanitary materials to allow them to safely and properly care for their bedridden parents. Direct financial support in the form of grants is an important consideration in addition to material support.

Improved nutrition

The steps being taken to improve the health and prolong the lives of parents, through clinic and home-based care, treatment for opportunistic infections, and

antiretroviral therapy, has to be strongly complemented by appropriate nutritional support.

Moreover, many children cited lack of food as one of the reasons for not attending school. School feeding programmes could play a role in improving nutritional intake, as well as the educational outcomes of these children.

Counselling and support

Material support for child-headed households has to be complemented by psychosocial support. Children need to have someone to offer them love, hope and affection; someone to turn to for help, advice, guidance, protection and support in times of crisis. They need the companionship of an adult to enable them to develop their full potential. Trauma counselling and access to play and recreational facilities are also important.

Life skills training

Younger children rely on their older siblings for emotional support and social guidance, so child household heads need to be better equipped with life skills to shoulder the responsibility of providing for the needs of their siblings as well as bedridden adults. It is necessary to offer training to child household heads to build their life skills in aspects such as health, sanitation and HIV/ AIDS, as well as building up their resilience to enable them to overcome bereavement and trauma, and face the challenges of stigma and discrimination.

Generating income

Older siblings in child-headed households need to be given opportunities to set up income generation programmes, by offering vocational training and start-

up capital accompanied by thorough training, support and monitoring for the children. “Our house is by the road; if I had sufficient capital, I would set up a small business and support my family,” said a sixteen year-old boy heading a household of four in Dessie.

The provision of labour saving technologies to child-headed households can help them to earn an income while alleviating the household labour burden. Income generation opportunities such as silkworm production, which demand moderate amounts of strength and energy, are particularly worth pursuing.

Community involvement

It is important to mobilise the community in support of child-headed households. Alleviating poverty and extending social security mechanisms to poor families at community level will have trickledown effects in enabling overstretched extended family networks to absorb orphans.

Community mobilization includes providing mentoring and counselling training, and material support to community volunteers. Such volunteers can make regular supportive visits to child-headed households,take an interest in their progress at school, monitor their health, involve them in recreational and social events, and offer care and love.

Planning for the future

Terminally ill adults have to be advised on proper succession planning, by empowering them to prepare wills, identify caretakers and make plans for care of their children. This is a taboo subject, but it is an area of critical importance for the future survival, safety and security of children.

Legal protection

Due to their vulnerability to property grabbing and sexual and physical abuse, child-headed households have to be given special legal and police protection, so they can defend their rights and access legal and police services, such as free judicial representation.

There is a need for the legal recognition of child-headed households, so that adequate supervision and support can be ensured, through entities approved by an official body, and directly or indirectly accountable to them. Legal recognition is critically important for formalising support from the government; for example, birth registration, access to healthcare and social security. It can also prevent such children from being dispossessed of their houses, land or property.

Tracing families

Family tracing and reunification might be one area of intervention for grassroots non-governmental and community-based organisations.

Further research

There is a need for further studies on the situation of child-headed households, especially in areas not covered by this study. The ethnic and cultural diversity of Ethiopia lends itself to varying responses to the situation of child-headed households, which are worth exploring separately and in greater depth. Similar studies should also be rolled out and replicated in other countries and regions of Africa.

Unless urgent steps are taken in these and other areas, millions of children parented by siblings will become adults whose emotional, social and educational development has been compromised.

Millions of these children who are acting as heads of households, playing an adult role before their physical and emotional maturity is ready, use their survival instinct to develop crude coping mechanisms. Many of them display '[a] capacity to cope with adversity in a manner that frequently belies their age.[30] As ACPF Executive Director, Assefa Bequele rightly put it, this is "... a phenomenon that proves the extraordinary resilience of children. But it is to be neither mystified nor idolised. It is at its best a pure and innocent expression of love of older siblings for their younger ones and the keeping of a promise made to a dying mother. But it is also mostly borne out of the compelling urge for survival, a desperate attempt to cling to life. " [31]

[30] O'Sullivan cited in Plan Finland (2005)

[31] Bequele (2007)

Annex I
Research methodology

Data gathering tools

Interviews

Semi-structured interviews were conducted with child heads of households, terminally ill parents in their homes, medical personnel, teachers, HIV/ AIDS activists and counsellors. Required data included quantitative information on household characteristics, basic demographic, epidemiological and socioeconomic information, as well as information on resources and other quantifiable demographic data on households headed by children.

The data collection process also involved semi-structured interviews with local authorities, NGO staff and selected officials from the Regional Bureaus of Labour and Social Affairs. These organisations were interviewed to ascertain their level of awareness and their activities geared towards alleviating the impact of HIV/ AIDS, including supporting child-headed households. They were also asked about gaps in current programmes and how they could be supplemented by community-based interventions or new legislation.

Case studies

Several case studies were collected, including special in-depth interviews with households headed by female and male orphans, and terminally ill parents living in child-headed households. The case studies, which use hypothetical names, help enrich the analysis by putting the issues in context.

Photographs

Photographs were taken upon consent of the respondents to reinforce the

messages in the data and to capture physical features such as living and housing conditions.

Personal observation

Walking around in the villages and towns, and visiting the affected families helped uncover vital information about household practices. It also helped to triangulate the information gathered through interviews and questionnaires.

Document reviews

Government and NGO reports were reviewed to determine the extent of the phenomenon. Existing studies and research on the subject were also studied to enrich the overall analysis and the recommendations.

Sampling methods

Purposive, convenience and stratified sampling methods were used to select the respondents. Child-headed households receiving support from NGOs active in the study areas were deliberately contacted for the study. Orphans living by themselves as a household with the support of informal support institutions, such as idir and religious institutions, relatives or neighbours, as well as those without any external support, were also contacted. Stratified purposive sampling was used to take stock of the various dimensions of cause and effect of the phenomenon and the coping strategies that child-headed households employ. The strata included age, gender, religion, ethnic group, location (urban/ rural), school grade, duration of establishment and household size. The study included a purposive sample of non-orphans who are established as child-headed households for other reasons than the death or incapacity of parents. Snowball sampling techniques were also used to follow chain referrals and explore people affected who do not have the

chance or the knowledge to access NGO or government services, so are not found in official records.

Participation, consent and ethics

Consent was obtained from respondents after they were informed about the nature of the study. They were assured of confidentiality and given the option to decline to answer any or all of the research questions. An attempt was made to identify a legal guardian and obtain informed consent for all households where minors were respondents. Enumerators were instructed on how to fully respect ethical standards related to research on children.

Social outreach workers and home-based care workers, most of them living with HIV, were employed in data collection. The arrangement made it possible to access people living with HIV who would have felt uncomfortable with a visit from an outsider with a different status. It also allowed respondents to speak openly without fear of stigma, given the intimate relationships developed with outreach workers. The interviews were conducted in a manner that did not infringe on the labour schedules, medical appointments and social commitments of interviewees.

As it was a participatory exercise, the study process itself helped create awareness among the community about the gravity of the challenge, and generate a collaborative spirit among stakeholders. It also contributed to an implicit assurance for child-headed households that they have not been forgotten or relegated to the margins of programme responses.

Methods of data processing and analysis

The collected data was entered into a computer for easier analysis. In preparation for data processing, questionnaires' responses were first given numerical codes

and value labels. Filled-in questionnaires were edited for consistency and technicalities, which also provided a second chance for experienced professionals to review and improve the overall quality of the data. A computer template for entry was designed using new software, CS Pro, which facilitates data capture in large-scale surveys and censuses. An experienced data entry clerk was employed for entry and the data was later converted into a statistical package (SPSS) for in-depth analysis and tabular presentation. The qualitative data obtained from observation, document review and interviews was analysed manually both during the course of data collection, as well as afterwards.

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The African Child Policy Forum

P.O.Box 1179, Addis Ababa, Ethiopia

Tel: +251 (0)116 62 81 96/ 97

Fax: +251(0) 116 62 82 00

Email: info@africanchildforum.org

Websites: www.africanchildforum.org

www.africanchild.info

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