"WE ARE ON OUR OWN": CHALLENGES FACING CHILD HEADED HOUSEHOLDS (CHH), A CASE OF SEKE RURAL AREA IN ZIMBABWE

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ABSTRACT

African societies have been known for their strong family support systems that view children as society's future and as an important fabric if humanity is to be perpetuating itself. The family system in Zimbabwe has undergone some changes owing to devastating effects of HIV and AIDS and the economic meltdown that beset the country from 2000 through to 2015. In a normal Zimbabwean set up, children were supposed to be catered for by adult members of their immediate family first and foremost. The extended family and to some extend the community were expected to be alternate carers. Now there is a new family set up: the child headed households (CHH). This research employed qualitative methods to establish the daily experiences of 10 CHH. The research established that CHH faced immense difficulty in providing for their daily needs including food, education and clothing. They also lack psychosocial support such as guidance, love, belonging and protection. They note that while they were still loosely integrated in the extended family system, they were mostly on their own when it came to fending for the family. One participant noted "...our father's relatives could have taken us in, but I guess they are also heavily constrained. We take each day as it comes. We are on our own but we have not allowed our situation to extinguish the desire of success in us. We do not blame them. We have to move on our own".

KEY TERMS: Children, child-headed households (CHH), HIV, AIDS, extended family, economy, Zimbabwe

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INTRODUCTION AND BACKGROUND

African societies have been known for their strong family support systems that view children as society's future and as an important fabric if humanity is to be perpetuating itself. The family support systems underwent some changes due a number of reasons. In Zimbabwe, the system has undergone some changes owing to devastating effects of HIV and AIDS and the economic meltdown that beset the country from 2000 through to 2015. In a normal Zimbabwean set up, children were supposed to be catered for by adult members of their immediate family first and foremost. The extended family and to some extend the community were expected to be alternate carers. Now there is a new family set up: the child headed family, often referred to as child headed households (CHH).

A CHH is defined as a family unit of which the oldest person residing in the household is under the age of eighteen (UNICEF, 1998). This is the same definition used by the Seke Rural Home Based Care (SRHBC)

which runs community care programs in the community where this research was done (SRHBC, 2011). The responsibility of care in such a home is in the hands of a person younger than eighteen years. The responsible child ensures that other members of the family, normally children, have basic needs. This is a recent phenomenon; a reaction to the gap left by a deteriorating family set up. As SRHBC (2011) argues, there are several reasons behind this development. These include the ever presence of orphans in the Zimbabwean society. Further, some extended families that would normally take up this role are also grappling with their own orphans. For the same reason, the community is heavily burdened too. This leaves orphaned children with nowhere to go but to care for themselves. The review of literature below gives an insight into what is already known about CHH.

LITERATURE REVIEW

There is a vast amount of literature available on CHH. A search of major research databases shows a whole range of researches from Africa. For the purpose of this review,

only researches carried out in Zimbabwe were considered.

In their comparative analysis of impact of alternative care approaches on psychosocial wellbeing of orphans and other vulnerable children (OVC) in Zimbabwe, Takaza, Nyikahadzoi, Chikwaiwa et al (2013) found out that community systems were more rewarding compared to institutional systems. The study utilised a structured questionnaire to gather data from three institutions that were using the three different models of children care. In Zimbabwe, institutional care and community care approaches are all used. This research recommends community care.

In another research on orphans and vulnerable chidren in Zimbabwe, Dziro, Mtetwa, Mukamuri et al (2013) looked at children in residential care institutions and found that such children tended to exhibit a serious lack of proper grooming in African culture and values, which phenomenon predisposed them to negative behavioural tendencies. The paper recommends the adoption of an

Afro-centric model of residential care for children in Zimbabwe. In the paper, the authors placed value on community based care approaches.

Roalkvam (2006) brought a new dimension to literature on orphans and vulnerable children. Using ethnographic approaches in the same area (Seke) this research was done, the researcher suggested that orphaned children ultimately stand alone because they are left in a specific time, in a specific situation, when the relationships that should surround them still have to be made, recognised and named. In short, their parents die when their (maternal and paternal) two families have not reached strong bonding. The argument was that explanations of why households become child-headed based on weaker community systems, were inadequate. The researcher argued that prevailing explanations, such as HIV/AIDS-related stigma, poverty or anomie, are insufficient for understanding the isolation of the child-headed household and situations when children, in what should be a protective relationship, are exploited or abused.

In support, Germann (2006) researched on child headed households in Zimbabwe and found that the key determining factor contributing towards the creation of a CHH was 'pre-parental illness' family conflict. Another contributing factor was that siblings wanted to stay together after parental death. The researcher also found that despite significant adversities, over 69% of child headed households reported a 'medium' to 'satisfactory' quality of life and demonstrate high levels of resilience.

Ciganda, Gagnon, and Tenkorang (2006) looked at child and young adult-headed households in the context of the AIDS epidemic in Zimbabwe between 1988 and 2006. Using the Zimbabwe Demographic and Health Surveys (1988, 1994, 1999, 2005/2006), they found out the proportion of households with no adults remained stable, although the number of orphans increased significantly. They found a large number of children living in child-headed households were non-orphans, suggesting that this kind of living arrangement is not always a direct consequence of parental death. They showed that children living alone were less likely to have unmet basic

needs than children in households headed by working-age adults and in other vulnerable households, although other studies suggests otherwise.

Taking a sociological perspective, Francis-Chizororo (2006) researched on child-headed households and recommended more research on their experiences. The research noted that sharing of roles followed what happens in society generally. In similar fashion, Mavise (2011), explored the constraints and opportunities in children's decision-making in 30 child-headed households in Harare, Zimbabwe. Findings revealed that some of the children were active agents who tried in their own way to make sense of their situations and to act within their capacities to improve their experiences. The researcher recommended that there is need to take decisions of the children in planning for their future.

These research bring very important dimensions to this research. Firstly, they provide empirical evidence in support of community based practices. Second, they provide the other side of community approaches in

relation to CHH, providing alternative viewpoints. The research reported in this paper built on this literature and sought to add to available knowledge on CHH focusing on their experiences especially in relation to responding to the question if their basic needs were being met or not. It did not however, endeavour to compare CHH with children in non-CHH.

METHODOLOGY

The research intended to get an insight into the experiences of children living in CHH and to identify needs of such households. It was carried out in Seke community, which is a semi-arid and peri-urban area. Most of the people in the area depend mainly on gardening and daily piece jobs in nearby urban areas like Dema, Chitungwiza, Marondera and Harare.

A qualitative research design was employed in which in-depth interviews with 10 heads of child-headed households, three health and social services staff and five home based care givers. The 10 child headed families all in all had 26 members. Staff that participated in the study

were employed by SRHBC, a community based organisation based in Seke. They included two social workers and a community nurse. The staff were chosen because they interacted with most of the children on a daily basis.

Further to the in-depth interviews, observation and assessments of the households' living standards were made to bolster the information gathered from the 10 interviews. Data were then read several times, thematically analysed and presented.

FINDINGS

The findings from the interviews are presented in this section under several headings. Each heading is represented by a theme generated from the analysis.

We should have lost our mother first

The entire 10 CHH lost both parents. Of the 10 families, two families lost their mothers first while the remaining eight lost their fathers first. Respondents noted that given a preference, they would have opted to lose their fathers

first. Reasons cited for the choices included the fact that fathers were not as caring as mothers. They noted that mothers go the extremes in providing for their children. Other respondents also noted that their fathers tended to have divided attention as they sought solace with other women outside hence this impacted on the well-being of the children. On exceptional cases, respondents noted that some fathers stood by their families while other mothers especially the young women tended to marry and move on thereby leaving behind children without adequate care.

It looks like we are not part of the extended family

Two of the households did not know relatives of their parents. The father was from Mozambique who had come to Zimbabwe during the Mozambique's civil war. The mother was from Malawi. Extended family members in existence included grandparents, aunts and uncles. There were a number of reasons why these children were not living with their extended family. Three child headed households said they had not been offered the opportunity to live with their relatives. Four of them said

that their relatives were financially unable to support them.

One participant noted that "*...our father's relatives could have taken us in, but I guess they are also heavily constrained. We take each day as it comes. We are on our own but we have not allowed our situation to extinguish the desire of success in us. We do not blame them. We have to move on our own".*

Some of us have lost our right to education, some of us are uncertain about our future

Nine of the children are attending school. Six at primary school, three at secondary school and one is undertaking vocational training. Four had been forced to drop out of school to fend for their siblings. More children were attending primary school because fees were cheaper as compared to secondary school. Further, government's Basic Education Assistance Module (BEAM) was paying school fees for the three who were at secondary school. BEAM covered only tuition fees leaving uniforms, building fund and books which are even more expensive

than the fees themselves. SRHBC was supporting with building fund and uniforms to complement BEAM. For those in primary school, SRHBC was also paying all the fees and uniforms for the children. It is unfortunate that SRHBC and BEAM were only catering for children who were at school leaving out those ones who had dropped out of school due to financial difficulties. The unfortunate part of it was that SRHBC's funding on school assistance was coming to an end in mid-2013. No one knew what was going to happen to these children.

We are food insecure, we are not eating enough

The seven households interviewed were very food insecure. All the ten families were also getting food hand-outs from SRHBC. The hand-outs were not adequate to see them through to the next round of rations distribution. One family indicated that they shared their ration with their grandmother, worsening the situation of these children. As a result of this SRHBC took it upon itself to keep food for this household and only give them what was enough for a week or so. The issue of food insecurity was so severe in the family of two young boys.

The younger one was HIV positive. The food problem was affecting him very much. This was so because he was supposed to take food always as it was difficult to take ARVs with an empty stomach. The two boys shared the same father but had different mothers. Their situation created a strong bond between them.

All the seven families were trying their best to grow crops for self-sustenance, but due to droughts and lack of inputs they were failing to harvest meaningfully. What they were getting was not enough for the whole year. One family was doing well through gardening. They were managing to sell some of their produce at Chikwanha market, but the rest were finding the going tough.

One of the households of two young boys had no cooking pots, plates and other spoons. These were later provided by SRHBC. All what used to belong to their parents were taken by their parents' relatives. The older one was 12 years old and the younger one was nine years old. They had their family house they were renting out in

nearby Epworth area but the grandmother was the one who was benefiting from the rent from the house. The two boys were not benefiting anything.

Some of us are ill and stigmatised

In relation to health, three of the family members had one or two members who were HIV positive. They were facing a number of challenges which included stigma from their peers, problems in dating and disclosure issues. In dating one teenage girl was facing problems in disclosing her status to her boyfriend. She feared rejection by the boyfriend and her relatives.

Another boy who stayed with his brother had problems with drug adherence. He had no one to remind him to take his drugs. Adherence to ant-retroviral drugs ensures the suppression of replication of HIV, thus restoring the immune system and improving the survival and quality of life for the young boy. SRHBC assisted the boy with resources to go for CD4 count and for the boy to be put on ARVs. He was assisted with transport to and from the Chitungwiza General Hospital. Apart from that they

assigned a field officer who resided near the boy to assist him with drug adherence. The organisation also ensured that the young boy on ARVs had access to non-judgemental and supportive counselling so that he felt free to share the challenge he faced with other stakeholders who cared about him including school authorities, his class teacher, community caregivers and some villagers.

Our living conditions are not desirable

Seven child headed families had blair-toilets at their homes. Five of them had protected wells. Two were fetching water from nearby boreholes. Two families of these seven were living in dirty and unhygienic circumstances.

Abuse has not spared us

Children interviewed reported that they had experienced abuse of some sort since becoming a child headed household. Two reported physical and verbal abuse, one reported an attempt of sexual abuse had been made towards her, six reported being exploited and two

reported neglect by a member of the extended family prior to becoming a child headed household. When they experienced abuse, or other problems, the households said that they had no one to turn to for help. These abuses were never reported to SRHBC, the police or traditional leaders due to fear of being reprimanded by the perpetrators.

Many of the heads of these families did not have the skills or knowledge to ensure that they protect themselves from exploitation and abuse.

We depend on community care givers, the community is not fully interested

Community care givers were main sources of help for most of these children. One family had no-one to turn to in terms of financial assistance. Five of the families reported that they had no one they felt they could turn to for emotional support. One family said they were able to talk to a teacher about their problems. Two families said they supported each other and one child confided in a friend.

However, SRHBC which supports the home based care givers was very worried about these children. The organisation was failing to cope with the problems of these families. This was so because it did not have adequate resources to address all their needs. To make matters worse the voluntary organisation had no adequate funding for most of the activities it was rendering to these families.

The community looked like it did not care about the children and this might be because "*people have too many problems of their own*" (Home based care giver). Another care giver thought "*Child headed households are seen as a problem by the community because of their anti-social behaviour by the communities (being aggressive, withdrawn, and uncommunicative)*". The level this statement could be taken as true was not ascertained.

The community at large assisted the children in different ways according to the children. Some donated food,

some clothing and at times assisted with school fees. In most cases some community members gave these children some pieces of work to do such as heading cattle, weeding in their fields or gardens. In return they got cash and sometimes food. These children were sometimes underpaid: what they got for their services was not equivalent to their effort.

Although these were common problems faced by many orphaned children in a range of different circumstances, it was felt that child headed households were much more vulnerable and at risk because they did not have the material and personal resources to cope with the problems that they encountered on a daily basis.

We feel hopeless

In general there was a sense of downheartedness and lack of hope in the households. Only one child interviewed spoke openly about their lack of hope for the future but there was an overall impression from the children of a sense of powerlessness to influence the future in any positive way.

Children interviewed feared that they could not finish their education and should they finish they were not sure if they could proceed to and have a professional course. This was so because more money was required for college education. Two families feared that they would not be able to stay together and look after each other in future. And one child expressed his fear that he would never get a birth certificate and might not be able to have a good life. Confidence was lacking from these families. This could be attributed to conditions they went through after the death of their parents. Lack of parental and guardian support affected these families a lot. They did not know what the future held for them. Two of children who were HIV positive feared dying and were not sure if they would ever marry and have children of their own. They had fear of not enjoying motherhood and fatherhood like any other person in the future.

When asked what they hoped the future would hold for them, the largest proportion of the children expressed the hope for a good job. Some hoped that they would be

able to complete their education and one child talked of his wish to proceed to university. Two of the children expressed their wish to start their own businesses or income-generating projects. All of these children felt that given an opportunity for appropriate training and access to resources they would be able to support themselves and their younger siblings. The extent to which these children would realistically undertake and make a success of an income generating enterprise was unclear. Children simply expressed the hope that their life would become better in the future and two also said that they hoped that the family would be able to stay together. Three children had no hopes for the future. Most of children talked to, had 'shut down' their emotions as a survival strategy to help them cope with their difficult circumstances.

What needs to be done?

More should and could be done to help the orphaned children in their community. The community could offer moral support to the child headed household even if they were not able to offer material support. They could offer

"guidance", "advice" and "teach them about life", (Home based care givers). Organisations like SRHBC should be *"empowered financially for them to be in a position to look after these children properly. These organisations they can assist these children through helping them to start income generating projects*", said one social worker.

Home based care givers noted that there was need of educating these child headed families in running income generating projects successfully and to ensure material support is made available by government and non-government organisations. *"The biggest role of SRHBC is of offering material support, in raising awareness, in liaising with the Department of Social Services and other stakeholders on issues affecting these children."* SRHBC could help by training the community in counselling skills and could do training workshops with the children to teach them life skills.

The government should put policies which are user friendly to child headed families to allow them to attend

school for free. *"I want to be allowed to attend school without being chased for lack of fees"*, (Child, 14 years).

SRHBC expressed fears for the children's future. The largest concern was that serious financial and food shortages would mean that the capacity of the community to help would be further eroded. There were worried about the risk of abuse and also feared that the children would become criminals if not properly looked after.

SRHBC was of the opinion that the parents should save money (insurance) so that the children would have resources should the parents pass away. The organisation said that parents should talk to the children and give them advice so that they will know what to do and who to go to for help. The parents could identify who they would like to care for the children after their death and make the arrangements. SRHBC also felt that children should be taught to be self-reliant so that they are equipped to cope if they lose their parents.

DISCUSSION AND RECOMMENDATIONS

There were two main gaps in the support available for child-headed households: material support and psychosocial support. This is supported by findings from previous research by Takaza, Nyikahadzoi, Chikwaiwa et al (2013) and Francis-Chizororo (2006). There is a clear need for appropriate interventions to address the immediate needs of child-headed households in communities and to develop sustainable responses to these needs which can be both responsive and preventative in nature.

It is recommended, therefore, that short-term interventions are implemented to provide material support for child headed households until such time as the community are able to offer this support (Child Protection Society, 1998). This material support should, however, be offered in conjunction with psycho-social support activities which involve the children themselves and key stakeholders in the community so that community safety nets can be built and sustained and the community can be empowered to access other more

lasting sources of support (Paediatric Association of Zimbabwe, 1994, Hove, 1999).

As recommended by Mavise (2011), there is also a need to undertake preventative work, to create an environment where the community no longer find it acceptable to have children left unsupported and strategies are developed to prevent this happening.

It is further recommended that psycho-social support interventions be initiated targeted at key stakeholders in the community (Powell, 1990). In addition, the orphaned children themselves should be targeted for training to build their life skills in aspects such as health, sanitation, HIV and AIDS as well as building up their resilience and enabling them to overcome bereavement, trauma and stigmatization (Powell, Chinake, Madzinge and Maambira, 2004).

Peer support is also necessary. There is growing evidence that young people are able to offer effective psycho-social support for younger orphaned children (Powell,

1990, UNICEF, 1998), are often able to help them through problems and crises and are better able to talk to them about sensitive subjects such as abuse (Mavise, 2011).

It is also recommended that community members foster these children. Kaseke and Gumbo (2001) argued that this is important since communities may feel part of initiatives to reduce challenges of orphans. Foster (1993 agrees that this way, material resources for child-headed households increase.

CONCLUSION

Child-headed households are living in very difficult circumstances without basic needs and sustained adult guidance. Support mechanisms within communities are generally ad hoc and lack a cohesive and comprehensive response to the needs of child headed households and other vulnerable children. In addition, the social and economic stress being experienced by communities puts any existing responses under severe strain and exacerbates the feelings of insecurity and hopelessness

felt by orphaned children and child headed households especially.

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