

**QUALITY OF LIFE IN A FRAGILE STATE: A STUDY OF ORPHANS  
AND VULNERABLE CHILDREN LIVING IN CHILD-HEADED  
HOUSEHOLDS IN ZIMBABWE**

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## DECLARATION

I, **Kudzai Emma Chademana Munodawafa** hereby declare that the thesis “**Quality of life in a fragile state: A study of orphans and vulnerable children living in child-headed households in Zimbabwe**” which I submit for the degree of Doctor of Philosophy in Public Health at the University of the Western Cape, is my own work and that it has not previously been submitted for any degree at another University. I also declare that all sources used have been duly acknowledged.

28/06/2017  
Date.....



  
Signature .....

## DEDICATION

To my nieces, Ruva and Anashe Munodawafa



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My profound appreciation goes to –

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## LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
AU	African Union
BEAM	Basic Education Assistance Module
CCW	Community Childcare Workers
CHH	Child-headed household
CPC	Child Protection Committee
ESAP	Economic Structural Adjustment Programme
GDP	Gross Domestic Produce
HIV	Human Immunodeficiency Virus
HSCT	Harmonized Social Cash Transfer Programme
IUCN	The International Union for Conservation of Nature and Natural Resources
NAP OVC	National Action Plan for Orphans and Vulnerable Children
NGO	Non-Governmental Organization
OVC	Orphans and Vulnerable Children
QOL	Quality of Life
SADC	Southern Africa Development Community
SOWC	State Of the World's Children
STI	Sexually Transmitted Infections

UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCRC	United Nations Convention on the Rights of the Child
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNISA	University of South Africa
WFP	United Nations World Food Programme
WHO	World Health Organization
WHOQOL	World Health Organization Quality of Life
WHOQOL-BY	World Health Organization Quality of Life BREF Youth
ZimVAC	Zimbabwe Vulnerability Assessment Committee
ZNCWC	Zimbabwe National Council for the Welfare of Children



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## ABSTRACT

Households headed by children, adolescents and youths are a growing phenomenon across sub-Saharan Africa. This is largely a result of the increasing mortality of economically active adults, coupled with migration and urbanisation, which have all weakened traditional kinship systems. Children and youth living in these households experience myriad challenges arising from the absence of an adult guardian and economically active household member. Several studies have shown that children living in these child- and adolescent-headed households experience extreme poverty and deprivation. Furthermore, Zimbabwe's precarious socio-economic condition could further exacerbate these children's risks and deprivations. The wellbeing and quality of life of orphans living in these child-headed households is not well understood as there are very few studies that provide a holistic perspective on the experiences and quality of life for those in these households. The aim of this study was to assess the quality of life of orphans living in child-headed households in Zimbabwe, and explore the factors that influence their quality of life.

The study was divided into four phases – situation analysis, cross-sectional survey, ethnography, and validation of findings. The situation analysis was exploratory; whereby in-country perspectives of the experiences of orphans living in child-headed households and their context were explored. In-depth interviews, focus group discussions and a document review were used in data collection. Perceptions were that child-headed households are established as a result of migration, poverty and weak kinship.

The cross-sectional survey assessed psychological health, physical health, social relationships, environmental and general quality of life perceptions of 96 orphans living in child-headed households in Zimbabwe. The majority of the participants had positive scores in the psychological domain, although some participants indicated experience of psychological distress such as depression and anxiety. In the physical domain, a few participants indicated experiencing physical pain that affects their daily performance, and indicated that they needed medical attention to function daily. Participants were dissatisfied with the *support they received from others*, even though the majority were satisfied with their *social relationships*. In the environment domain, the majority of participants were satisfied with their *physical environment*

but indicated dissatisfaction with their *living environment*. Overall, the majority of participants were dissatisfied with their life.

The third phase of the study was an ethnographic inquiry, using in-depth interviews and observations, to explore factors influencing quality of life amongst seven children and adolescents living child-headed households in Zimbabwe. Factors influencing quality of life in child-headed households were identified as lack of resources, poor housing structures, poor living environment, food insecurity, poor access to services, failure to realise education, the absence of adult guardians, social isolation and financial insecurity. However, there was also observed cases of resilience and agency, as orphans adopted creative coping strategies to generate income.

The fourth phase involved the validation of the findings from phases 1-3 through stakeholder workshops. The results also include recommendations to improve quality of life in child-headed households in Zimbabwe.

A major theoretical implication of this study is the significance of social comparison in influencing children's perceptions of their wellbeing and quality of life. Life satisfaction amongst orphans was influenced by past experiences, and was relative to the community in which child-headed households lived. This study concludes that the rights of children living in child-headed households are not realised; therefore, the study makes the following recommendations – i) facilitate access to birth certificates; ii) implement an adult mentorship program to address the challenge of the absence of adult support and guidance, in child-headed households; iii) provide alternative education options; and iv) establish community centres that provide services to child-headed households.

# CHAPTER 1

## INTRODUCTION

### 1.1 Introduction

This thesis explores the quality of life of orphans living in child-headed households in the context of Zimbabwe's fragile state. This first chapter introduces the study presenting the background, rationale as well as the aim and objectives of the study. An overview of the burgeoning orphan crisis in sub-Saharan Africa and how this has led to the establishment of child-headed households is presented. To contextualise the study, the socio-economic and political situation in Zimbabwe is discussed. This study consists of four sequential phases which include a situation analysis, cross-sectional survey, ethnography and validation of findings. An overview of these phases is presented. The chapter closes with an outline of the thesis.

### 1.2 Background

Sub-Saharan Africa is disproportionately affected by the HIV pandemic and continues to be the global epicentre (Francis-Chizororo, 2008). Latest statistics from the UNAIDS (2016) estimate that in 2015, sub-Saharan Africa had 19 million people (adults and children) living with HIV. In 2015 alone, there were 960,000 new infections in the region (UNAIDS, 2016). East and Southern Africa are the most affected with the highest prevalence rate globally of over 7% (UNAIDS, 2016). However, there has been a decrease in HIV-related mortality, from 760,000 in 2010 to 470,000 in 2015 in East and Southern Africa (*ibid*), which can be attributed to the availability of life-saving antiretroviral therapy. Despite this decrease in the mortality rate, the impact of the epidemic is long term and far reaching, and will continue to be felt for years to come.

Children, in particular bear the brunt of the epidemic: the United Nations Convention on the Rights of the Child (UNCRC) Committee points out that the HIV epidemic has direct and indirect adverse impacts on children (UNCRC Committee, 2003 *in* Lim, 2009). Firstly, children assume caregiving and livelihood roles in the face of parental morbidity and mortality (Moffett, 2007). In many cases, children drop out of school and experience poverty, food insecurity, malnutrition and poor health.



These multiple deprivations push children further into poverty, thereby increasing their vulnerability to the epidemic, creating a vicious cycle of HIV/AIDS and poverty, which Masanjala (2006) describes as the “poverty-HIV/AIDS nexus”.

Furthermore, the epidemic leaves many children orphaned, as parents and guardians die. Although there is evidence of a declining epidemic in some parts of sub-Saharan Africa, the number of orphans will continue to grow as a result of the long time-lag between HIV infection and death (Moffett, 2007). The *State of the World’s Children 2016* report (UNICEF, 2016) indicates that 7.6 million children in East and Southern Africa were orphaned by HIV/AIDS in 2014 alone, making up more than 57% of the global total. In countries that are hit the hardest by the epidemic, the numbers are alarming, as indicated in Table 1.1. Although HIV/AIDS is not the only cause of orphanhood, figures in Table 1.1. indicate that HIV is the leading cause of parental death, accounting for over 50% in Southern Africa with the exceptions of Uganda, Mozambique and Zambia.



**Table 1.1 Number of children orphaned by HIV/AIDS in 2014**

Country	Orphaned by HIV/AIDS in 2014	Orphaned on account of all causes in 2014
Botswana	67,000	100,000
Lesotho	74,000	120,000
Uganda	650,000	1,900,000
Mozambique	610,000	1,800,000
Namibia	53,000	100,000
Malawi	530,000	990,000
South Africa	2,300 000	2,800,000
Zambia	380,000	950,000
Zimbabwe	570,000	810,000

Source: UNICEF, 2016. *State of the World’s Children 2016 Report: pages 130 - 133*

Traditionally, orphaned children are absorbed by the extended family, which is the traditional social security system (Foster, 2002). However, with this overwhelming rate of HIV-related deaths, extended families can no longer cope with the additional burden of absorbing orphans (Hope, 2005; Dalen, 2009; Foster, 2004). According to the *State of the World's Children 2016 Report*, over 46 million children in sub-Saharan Africa have lost one or both parents (UNICEF, 2016). Foster (2000:55) points out that “the extended family is not a social sponge with infinite capacity to soak up orphans”. This capacity has been diminished as a result of a combination of the increasing number of orphans, and poverty. Furthermore, the increasing mortality of economically active adults has diminished both communities’ and families’ abilities to absorb and support the growing number of orphans. In addition, migration and urbanisation transformations have weakened traditional kinship systems (Foster *et al.*, 1997; Awino, 2010).

This has led to the formation of new household structures, *child-headed households*, as children are left to live alone and look after themselves (Foster, 1997: 155; Donald and Clacherty, 2005). In a child-headed household, the main caregiver and breadwinner is below the age of 18 years (Sloth-Nielson, 2004). Child-headed households are a growing phenomenon in many African countries. There is however a dearth of country statistics of children living in child-headed households. South Africa has over 150,000 children living in child-headed households while Uganda has 25,000 child-headed households (UNICEF, 2015). Consequently, they are increasingly being recognised as household structures.

This phenomenon of child-headed households is complex and multi-faceted (Mogotlane *et al.*, 2008). Some child-headed households are formed long before orphanhood, when children look after their ill parents (Moffett, 2007), while others are established as a temporary measure, after parental death. It is also important to note that not all child-headed households are indicative of the failure of the extended family to absorb these children. Some child-headed households are formed as a result of children choosing to stay alone and not being willing for various reasons (discussed in the literature review chapter), to move in with relatives.

The wellbeing and quality of life of orphans living in these child-headed households is influenced by individual, community and macro-level factors. Individual factors influencing wellbeing and quality of life of orphans encompass lifestyle choices such as how children look after their bodies and behavioural choices such as smoking (Dahlgren and Whitehead, 1991). Community level

factors refer to both geographic locality and social network factors (Pike, 1995). Geographic factors such as housing, water and sanitation, electricity, safety, distance to school and proximity to healthcare facilities all influence quality of life. In addition, social and community networks consisting of family, friends and religious and community members are critical to the health and quality of life in child-headed households, as they are children's social capital. Social and community networks are particularly important in child-headed households, as they lack adult guardians and support. Thus, the absence or weakening of these networks can negatively affect children's wellbeing. Importantly, the macro-level context of child-headed households is crucial in influencing their quality of life. In particular, structural factors such as economic stability, food security and employment directly and indirectly affect child-headed households. The current study explores the quality of life of child-headed households in Zimbabwe, in the context of the country's socio-economic and political environment, presenting both vulnerability and resilience-enhancing conditions.

### **1.3 Problem Statement**



The challenges experienced by children living in child-headed households are not well understood, as they are often grouped in the broader category of “orphans and vulnerable children” along with other vulnerable children from adult-headed households. However, the vulnerabilities of this group of vulnerable children are unique as: i) they often do not have an adult guardian to represent them and assist them to access services; and ii) they are an invisible population that is difficult to trace as they are often out of school, highly mobile, may not have birth certificates and are thus undocumented. As a result, children from child-headed households are often left out in OVC targeted interventions.

These children are particularly vulnerable in several ways. Firstly, living in a household with no adult guardian, exposes these children to multiple risks such as physical and sexual abuse and exploitation (van Dijk, 2008; UNICEF, 2007). Furthermore, children miss out on the essential process of socialisation where they should acquire societal norms and values. Secondly, the absence of an economically active adult exposes children to the multiple deprivations of poverty, food insecurity and malnutrition that could negatively affect their quality of life and diminish their

future prospects. Furthermore, Zimbabwe's rather precarious socio-economic condition could further exacerbate the risks and deprivations that these children face. Noting the vulnerability of children living in child-headed households, the UNCRC Committee recommends that special attention be given to this group of vulnerable children (UNCRC Committee 2003, *in* Lim, 2009). More research on the unique vulnerabilities of child-headed households is required.

As the existence of this type of household is increasingly being acknowledged, research on them is gaining momentum. Several studies on child-headed households have been conducted across sub-Saharan Africa (Foster *et al.*, 1997; Francis-Chizororo, 2008; Foster, 2000, 2002, 2004; Foster and Williamson, 2000; Chimedza, 2001; Luzzo, 2002; Chipfakacha, 2002; Gelman, 2003; Nkomo, 2006; Masondo, 2006; Germann, 2002, 2003, 2006; Mkhize, 2006; Moffett, 2007; Mthethwa, 2009; Lim, 2009; Awino, 2010; MacLellan, 2010; van Dril, 2012; Sibanda, 2015). A few of these studies were conducted in Zimbabwe (Foster *et al.*, 1997; Germann, 2005a; Francis-Chizororo, 2009). However, these studies were conducted prior to the country's economic collapse in 2007. The country is currently experiencing severe economic turmoil; thus the quality of life of orphans may have changed significantly. During this time and the transition period, literature on vulnerable children is scanty. Thus, the quality of life and wellbeing of orphans living in child-headed households in Zimbabwe's state of fragility is undocumented and not well understood. To ensure wellbeing and protect the rights of this vulnerable population group, it is essential to understand the quality of life and its influencing factors. This study therefore assessed the quality of life of children living in child-headed households in Zimbabwe and explored factors influencing their quality of life.

Many studies have, however, focused on a single dimension of quality of life (Korevaar, 2009; Awino, 2010; Masondo, 2006; Moffett, 2007; Mkhize, 2006; Nkomo, 2006). The current study provides a holistic perspective on the wellbeing of children living in child-headed households by assessing and exploring their quality of life, which encompasses psychological, physical, social and environmental dimensions. Furthermore, existing studies on child-headed households present their experiences from an "outsider's" perspective - this study captures and assesses children's quality of life from a subjective perspective using a combination of a self-assessed psychometric survey and ethnographic techniques.

## 1.4 Aim and Objectives

Given the above challenge, this study aimed to describe the quality of life of orphans living in child-headed households in Zimbabwe, and explored the dynamics of these children's quality of life. The specific objectives are to:

1. Explore "country" perspectives of child-headed households in Zimbabwe.
2. Assess quality of life of orphans living in child-headed households in Zimbabwe using the WHOQOL-BY psychometric tool.
3. Explore factors influencing the quality of life of orphans living in child-headed households in Zimbabwe.
4. Validate findings and develop recommendations to improve the quality of life in child-headed households in Zimbabwe.

## 1.5 Definition of Terms

### Orphan

A child that has lost either or both parents and can either be a maternal, paternal or double orphan (Lindblade *et al.*, cited in Maqoko and Dreyer, 2007).

### Child-headed household

A child-headed household is a household whereby the main caregiver is younger than 18 years of age (Sloth-Neilson, 2004).

### Youth-headed household

A household whereby the main caregiver is between 15 and 24 years of age.

### Quality of Life

"Individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns" (WHOQOL Group, 1997b: 1). This encompasses an individual's physical health, psycho-social well-being and social relationships.



### **Fragile states**

States where the state power is unable and/or unwilling to deliver core functions to the majority of its people: security, protection of property rights, basic public services and essential infrastructure.

### **Protective factors**

Protective factors are conditions or attributes in individuals, families, communities, or the larger society that, when present, mitigate or eliminate risk (Centre for the study of Social Policy, 2008).

## **1.6 Overview of Study**

A sequential multi-phased study design approach consisting of four phases was employed as illustrated in Table 1.2, which included a situation analysis, a psychometric survey, qualitative inquiry and validation of findings. In these four phases, a combination of quantitative and qualitative methods was used. Harms *et al.* (2010) rightly point out that the use of both qualitative and quantitative research methods is imperative in order to comprehensively and holistically describe the challenges experienced by orphans. The techniques and methods used to collect data are presented in detail in the corresponding chapters.

**Table 1.2 Overview of study phases**

Phases	Objective	Research Approach	Methods
Phase I	Explore in-country perspectives of child-headed households in Zimbabwe	Situation Analysis	<ul style="list-style-type: none"> <li>• Key informant interviews</li> <li>• Focus group discussions with Child Protection Committees</li> <li>• Document review</li> </ul>
Phase II	Assess the quality of life of orphans living in child-headed households	Cross-sectional survey	<ul style="list-style-type: none"> <li>• Survey using the WHOQOL-BY questionnaire</li> </ul>
Phase III	Explore factors influencing the quality of life of orphans living in child-headed households	Ethnography	<ul style="list-style-type: none"> <li>• In-depth interviews</li> <li>• Shadowing (ethnographic observation)</li> </ul>
Phase IV	Validate study findings	Participatory research	<ul style="list-style-type: none"> <li>• Stakeholder workshop</li> </ul>

### 1.6.1 Study Settings

The study was conducted in three settings in Zimbabwe - Harare, Chegutu urban and Chegutu rural districts. Harare is the capital city of Zimbabwe and the largest metropole in the country. Chegutu is a small agricultural town and former mining hub 103 km south-west of Harare: the district is divided between rural and urban settings, the rural district consisting of a combination of commercial farms and communal settlements.

These three sites were selected for two reasons. Firstly, the three sites represent the different economic and social settings - urban, rural and peri-urban, thus giving a holistic perspective. This enabled the capturing of diverse vulnerabilities and risks to the quality of life of child-headed households, as these are influenced by context. The study was thus able to assess the quality of life

of child-headed households in an urban context, rural context as well as a peri-urban context. A second reason for selecting these sites is the high numbers of orphans resident in them.

### **1.6.2 Ethics Considerations**

This study involved research with NGO officials, community leaders, adolescents and minor children under the age of 18 years. Children particularly are considered vulnerable in research situations (Young and Barrett, 2001), and research involving them is complex and can present substantial ethical challenges. Care and precaution was taken because of dilemmas such as maintaining confidentiality and protecting children from harm. Research with children living in child-headed households poses further challenges as often there are no legal guardians to provide consent for involving them. Principles stipulated in the 4<sup>th</sup> amendment of the 1964 Declaration of Helsinki (World Medical Association, 1996) were adhered to, including the provision of adequate information, obtaining informed consent and maintaining confidentiality. The ethical principles guiding this study as well as the challenges encountered are discussed in detail below.

#### *Ethics clearance*

Ethics clearance was obtained from the University of the Western Cape Research Ethics Committee. Secondly, as the official custodians of child welfare in Zimbabwe, the Department of Social Services and Child Protection was consulted and written approval to conduct the study was obtained. Thirdly, the researcher obtained training and certification in Research Ethics from the University of KwaZulu-Natal.

#### *Adequate information*

The first parameter guiding this study was that “adequate information must be provided to the research participants”. Before any data was collected, all participants and guardians were informed of the purpose and nature of the study, of the host institution, and the use and dissemination of data gathered. The research study was explained to each household separately, with children separate from adult guardians. Enough time was provided to discuss the research study, and participants could ask questions at any point of the discussion. Information was presented in simple, non-scientific and clear language that the children could understand and age-appropriate explanations



were used for different age groups (Merlo *et al.*, 2007). Older participants were provided with information sheets in either English or Shona.

#### *Voluntary participation*

Participants were informed that their participation was entirely voluntary, that the child could agree or disagree to take part without adverse consequences and could withdraw at any time of the research. Children who were unwilling to participate in the study were not coerced, their refusal was respected and they were not enrolled in the study. No payment or compensation was given to participants as this would have influenced children into participating.

There were concerns around the different power relations between the adult researcher and child participants which, it was thought, may make children less able to refuse participation or leave during the study. As James (2001) points out, children may find it difficult to refuse to participate in a research study, particularly after guardians have given their consent. To address this, three strategies were employed. Firstly, the researcher established rapport with participants and tried to adapt her language to suit their level. The researcher explained that she was a student at University and wanted to learn more about them, in an attempt to reduce the power gap between researcher and participants. This strategy was successfully applied by van Dijk (2008) in her study on child-headed households in South Africa. Secondly, the researcher was always dressed in simple and plain clothes with no jewellery and used public transport where possible to avoid creating a power stereotype that may intimidate participants or create expectations of financial and material gain. Thirdly, at various intervals, the researcher reminded participants that their contribution was entirely voluntary and they were free to withdraw at any time.

#### *Informed consent, assent and permission*

In research involving minors, both the child's assent and parental/guardian informed consent are required (Schenk and Williamson, 2005). Schenk and Williamson define consent as "the affirmative agreement of an individual who has reached the legal age of majority"; thus minors below the legal age of majority are not able to give consent, and instead, their active agreement or assent to participate in the study is obtained.

In this study, consent was sought at various levels. The first point of departure was obtaining permission from gatekeepers of the various communities. Verbal and in some cases written consent

to involve children in the study was obtained from Village Heads and Ward Councillors of the respective villages and Wards where child-headed households reside.

Secondly, written informed consent was sought from all study participants as well as assent from minors, as required in the 1946 Nuremberg Code and the 1964 Declaration of Helsinki which stipulate that voluntary written informed consent of human subjects is “absolutely essential” (McGrath, 2007; Wendler, 2010). Ability to provide assent depends on a child’s decision-making capacity (Merlo *et al.*, 2007), thus assent was sought from all child participants over 12 years old as they are considered old enough to comprehend and make decisions. Merlo *et al.* (2007) assert that at the age of 12 years, abstract thinking begins, enabling children to perceive situations multi-dimensionally and give independent opinions, although this may be influenced by context, culture and socialisation.

Child participants willingly provided their assent as rational beings without being coerced. Although Kipnis (2003) points out that children’s lack of capacity to make rational decisions increases their vulnerability in research studies, it is also important to appreciate that children are not only passive participants; they are also active agents and social actors with some degree of rational decision-making capacity, particularly in the case of children heading their own households, who make decisions about their lives on a daily basis. Thus, with adequate information, these children showed evidence of being capable of making decisions consciously and independently.

Furthermore, both the Declaration of Helsinki and the Nuremberg Code require permission from an adult or legal guardian for minors to participate in a study. The ethical guidelines for conducting research with children and adolescents jointly developed by Family Health International, Horizons, IMPACT and the Population Council indicates that in cases where guardians are not available, informed consent may be sought from adults that interact with the child, such as teachers, social workers and health care workers (Schenk and Williamson, 2005). Informed consent was sought accordingly from neighbours, community leaders and Child Care Workers or any adult that children considered as guardians.

### *Confidentiality*

A major ethical issue often raised in studies involving children is confidentiality of information. In this study, particular caution was taken to ensure confidentiality and anonymity, and no real names were used in the presentation of the data: pseudonyms were employed and households were given numerical codes. Data gathered was used purely for research purposes and only by the researcher and research assistant. Audio recordings will be disposed of within two years of the study being completed.

### *Best interest of the child*

Having experience in working and conducting research with children, thought and consideration of children's rights and wellbeing was given to designing the research methodologies. Unlike adults, children are more vulnerable to emotional and psychological distress and should be protected in research studies of an emotional nature. The research methodologies were flexible and sensitive to the participants. In particular, solicited diaries were discontinued as participants indicated that they were not comfortable reflecting and writing about their experiences, and preferred to talk about them instead.

The researcher was aware of the sensitivity of the research topic and made every effort to consciously adhere to the principle of the "best interest of the child" at all times, as stipulated in the UN Convention on the Rights of the Child of 1989 (United Nations, 1989). This meant that at all times, the rights and wellbeing of the child superseded the research objectives, and in cases where they clashed, the child's wellbeing took precedence. One example in the study, where the best interest of the child was applied, was when a participant indicated that she or he was experiencing extreme depression and psychological distress. Steps were taken to inform the Department of Social Services and Child Protection through the Community Child Care Workers (CCW). Cognisant of potential bureaucratic delays, the participant was simultaneously referred to a local NGO that provides psycho-social support to children and youth. In addition, as a mechanism to monitor and ensure child protection in the study, CCWs were present in most of the interviews.

This study involved sensitive issues such as the illness and death of a parent and abuse from community and/or family members. The National Children's Bureau (2003) guidelines assert that the possible impact of research with a child is particularly important if the participant will be

discussing painful and difficult experiences. The Bureau advises gathering information on local sources of help, which will be able to assist if necessary. Arrangements were made in advance for professional advice and assistance from a social worker in the Department of Social Services and Child Protection. Participants showing emotional distress were excluded from the study and the necessary referrals were made. Participants were also asked whether they were comfortable discussing and reflecting on their life experiences. They were constantly reminded that they were free to not answer any questions and could withdraw from the study at any time. Furthermore, to avoid possible stigma and discrimination of participants in their communities, the current study did not mention HIV and AIDS, nor did it specify or explore the cause of orphanhood.

In research involving children, there is often a dilemma between maintaining confidentiality and disclosing information for the best interest of the child. James *et al.* (1998 in van Dijk, 2008) indicate that in such instances where a child is at risk of harm, such as facing sexual abuse, the researcher has a moral obligation to intervene. To address this without breaching confidentiality, permission to disclose information to relevant authorities was obtained from participants before making referrals.

Acting in the best interest of the child in this study also meant that, although no financial or material incentives were provided, the researcher took the decision to purchase food and toiletries for households that were in dire need, as well as for the households where the researcher was staying during the ethnographic phase. The researcher was aware that this could potentially influence children's willingness to participate. This was not the aim, but at that stage of the study, a relationship of trust and of friendship had developed in some cases and from the researcher's perspective, the food parcels were not considered as incentives, but merely as a response to need. Also, traditionally in many Shona cultures, when visiting, one does not go empty handed, thus the parcels were culturally acceptable.

## 1.7 Organisation of Thesis

This thesis consists of nine chapters; the balance of the thesis is organised as follows:

### *Chapter 2*

The theoretical precepts that inform this study come from the World Health Organization Quality of Life (WHOQOL) conceptual framework and the Determinants of Health ecological model. These two approaches are unpacked in this chapter.

### *Chapter 3*

The chapter begins by discussing the experiences of orphans, followed by a discussion of the various definitions and typologies, formation, constitution and dynamics of child-headed households. The chapter examines existing literature on the vulnerabilities of children living in child-headed households in sub-Saharan Africa, situating the current study in the discourse of child-headed households.

### *Chapter 4*

Chapter 4 to 7 present, phases: 1 to 4 of the study. In Chapter 4, the methods and findings of the situation analysis of child-headed households in Zimbabwe are presented. Policies, programmes and interventions supporting these households, as well as gaps and limitations of these policies and programs are discussed.

### *Chapter 5*

Chapter 5 presents the Quality of Life Psychometric Survey; the methods used in conducting the survey are discussed in detail. The physical, psychological, social relationships and environmental aspects of children's quality of life are examined.

### *Chapter 6*

Chapter six comprises of the ethnography where factors shaping child-headed households' quality of life and well-being are explored in-depth. In particular, risk factors influencing quality of life that emerged are discussed. The significant, but often overlooked phenomenon of children exercising their agency thereby enabling resiliency is presented.

### *Chapter 7*

Phase 4, the validation of findings is reported in Chapter 7. The validation process is presented, including a summary of the findings and new themes that emerged from the workshop.

### *Chapter 8*

An extensive discussion of the factors influencing quality of life in child-headed households is presented in this chapter. Resilience enhancing factors are also discussed. This chapter synthesises findings from all four study phases.

### *Chapter 9*

The thesis ends with Chapter 9, which draws conclusions and implications of the study. Recommendations to improve the quality of life of children living in child-headed households are presented.



## CHAPTER TWO

### CONCEPTUALISING QUALITY OF LIFE

#### 2.1 Introduction

As a concept, 'quality of life' is ubiquitous and understood differently across various contexts and disciplines, and has multiple complexities of definition, measurement and levels of analysis (Igumbor, 2011; Ferrans and Power, 1992; Kring, 2008). Thus, the starting point is to unpack the various conceptualisations.

Cobb (2000: 6) accurately points out that “in order to measure quality of life, one must have a theory of what makes up a good life”. Thus, after defining quality of life, the next step in this chapter will be to provide a theoretical premise of the components of quality of life. This study draws on two theoretical approaches, the World Health Organization Quality of Life (WHOQOL) conceptual framework and the Determinants of health ecological model.

#### 2.2 Defining Quality of Life

As a concept, quality of life has been widely debated with regards to definition, components and measurement in the disciplines of economics, psychology, sociology and health. The concept has also been used interchangeably with the concepts – standard of living, life satisfaction, well-being, living condition, happiness and health status (Galloway, 2005). A literature review on quality of life identified over 100 definitions (Schalock, 2000 *in* Galloway, 2005). Popular definitions include the WHO's definition of quality of life as

an individual's perception of his/her position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (WHOQOL Group, 1997b: 1); Barcaccia's (2013:14) definition is another popular one: the general well-being of individuals and societies, outlining negative and positive features of life. It observes life

satisfaction, including everything from physical health, family, education, employment, wealth, religious beliefs, finance and the environment.

Galloway (2005) argues that quality of life is ambiguous and difficult to define due to the multiple and different ways in which it is used. Quality of life is a desired outcome in economic policies, in healthcare services, social services and other development programs; thus, it is a globally accepted aspiration (Rojas, 2014). As a result of this ambiguity, efforts, and attention to quality of life, have largely been on measuring it without providing a specific definition to the concept. Rojas rightly argues that conceptualisation must come before measurement. This chapter discusses the main approaches to the concept of *quality of life*, unpacking its definition, components and measurements. Galloway (2005) succinctly points out that the main debates on quality of life are centred on objective versus subjective approaches; uni-dimensional versus multi-dimensional; the role of values and culture; relative concept versus absolute concept.

### 2.2.1 Main Approaches to Quality of Life

There are various approaches to conceptualising quality of life. In particular, sociology and political science disciplines measure quality of life at the societal and population level, while psychology and the medical discipline are interested in the individual level of quality of life (Beham *et al.*, 2006). In the health discourse, quality of life is understood as a holistic concept that encompasses an individual's physical, mental and emotional states, and has been used to understand the impact of diseases and treatment interventions on patients' lives, in addition to the physical outcomes (Addington-Hall and Kalra, 2001). These different approaches to quality of life can be categorised into three main schools of thought – objective, subjective and a combination of these.

In the *objective* school of thought, quality of life is associated with material resources and objective living conditions in a particular society (Erickson, 1974 in Beham *et al.*, 2006). Measurements of quality of life in this school are at society level, with a country or region as the unit of analysis; these include measurements such as the Index of Economic Wellbeing and the International Living Index. Economic indicators such as life expectancy, gross domestic product, employment and poverty rates are also used to measure the quality of life of a society. One prominent approach in the objective school of thought is the level of living approach that defines



quality of life in relation to people's access to, and control over, resources such as money and property (Beham *et al.*, 2006). This approach has been criticised for its materialistic approach and failure to incorporate variations in lifestyle and personality – some individuals may value social relationships and personal fulfilment over accumulation of wealth (Bliss, 1993; *in* Beham *et al.*, 2006). The approach has also been challenged by studies that show subjective responses to life conditions.

For the current study, the level of living approach was found to be insufficient because it lacks psychological and social relationship dimensions, which may influence orphans' wellbeing, satisfaction with life as well as coping strategies and, ultimately, their resilience.

The *subjective* school of thought views quality of life as well-being, as perceived and experienced by the individual. This school argues that objective and similar living conditions may be perceived and experienced differently by different individuals, and thus quality of life should be understood as perceived by the individual (Beham *et al.*, 2006). The individual is the unit of analysis when measuring quality of life in this school of thought. Three popular approaches in this school of thought are the Subjective Well-being (SWB) approach, the Capability approach and the World Health Organization's Quality of Life approach. The subjective well-being approach encompasses satisfaction with life; satisfaction with life domains such as health, work and family; positive affect and negative affect. Quality of life is therefore influenced by factors such as attaining personal goals, contentment and satisfaction with current life, levels of anxiety and depression, and personal beliefs. This SWB approach argues that although a society may have access to material resources, the reactions of individuals to circumstances differ, and are influenced by their unique expectations, values and experience (Diener, 2000). Sen's (1993) capability approach defines quality of life in terms of a person's capability to achieve certain functioning such as being in good health and achieving self-respect. This approach, however, is uni-dimensional, disregarding other crucial components of quality of life such as an individual's macro-economic and physical environment, social relationships and psychological wellbeing.

Another subjective approach, quality of life, is proposed by the World Health Organization. The WHO is concerned with people's health and well-being; thus, it views quality of life from an individual level. This approach is multi-dimensional, encompassing physical health, psychological

wellbeing, social relationships, as well as surrounding cultural and environmental factors (WHOQOL Group, 1995b).

The concept of life domains approach posits that quality of life encompasses 11 domains – health, finance, paid employment, housing, family, friendship, living partner, leisure, religion, transportation and education (Lance *et al.*, 1995). These domains are organised hierarchically, with overall life being the broader domain in an individual's life. Staines (1980 in Beham *et al.*, 2006) and Wilensky (1960 in Beham *et al.*, 2006) theorise that individuals enhance their subjective wellbeing and life satisfaction through three mechanisms – *spill-over*, *segmentation* and *compensation*. In the *spill-over* mechanism, outcomes from one life domain, such as work, influence another domain, such as health and family. With *compensation*, individuals try to make up for deficiencies in one domain by seeking satisfaction in another domain. With the *segmentation* mechanism, individuals separate and compartmentalise life domains to prevent the spill-over effect, where experiences are transferred between domains.

The third school of thought views quality of life as a combination of objective macro-level factors and subjective perceptions. Three prominent approaches are: Veenhoven's (2000) four qualities of life framework (FQoLF); Allardt's (1993) *having, loving and being* approach; and the integrative quality of life approach by Costanza *et al.* (2007).

Veenhoven (2000) views quality of life as an umbrella concept consisting of different conceptions. Thus, he proposes a comprehensive approach to understanding quality of life – the four qualities of life framework, which consists of four indicators that represent the qualities of a person's life which can be assessed independently of each other (Rojas, 2014). The four qualities of life are i) live-ability of the environment, which are the external conditions that influence an individual's life, taking into consideration economic, social, political, geographical and environmental factors; ii) life-abilities of a person, which refers to an individual's internal characteristics, skills and capabilities that allow the individual to utilise opportunities to live a good life - this is similar to the Capability approach; iii) utility of a person's life, which refers to the value an individual contributes to others; and iv) an individual's satisfaction with his/her life (*ibid*) - this aspect overlaps with approaches such as the Subjective Well-being and WHO quality of life approaches. Allardt's (1993) *having, loving and being* model is based on meeting three basic sets of needs,

namely: i) *having* – focuses on material conditions necessary for survival such as income, housing, education and employment; quality of life is viewed as an objective construction; ii) *loving* is more subjective and emphasises social needs such as relationships; and iii) *being* defines an individual's state of being and integration into his/her society, and involves attaining needs such as involvement in leisure and political activities (Beham *et al.*, 2006).

The integrative quality of life model by Costanza *et al.* (2007:269), define quality of life as the “extent to which objective human needs are fulfilled in relation to personal or group perceptions of subjective well-being”. The authors view quality of life as the interaction between (i) an individual's specific human needs, (ii) opportunities to meet these needs; (iii) how they are met; and (iv) perceived satisfaction at meeting these needs. The strength of this model is the inclusion and recognition of the role that macro-level policies play in impacting quality of life. In the model, policy creates an opportunity for human needs to be met, and also creates the conditions that increase the likelihood of people taking advantage of these opportunities. For example, education policies that provide fast track and out of school programmes afford children who are out of school an opportunity to complete their education.

Table 2.1 below summarises the major approaches to quality of life, along with their measurement indicators.

**Table 2.1 Summary of major quality of life approaches**

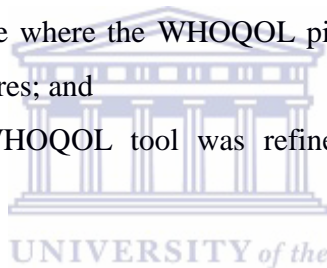
<b>Theoretical Approach</b>	<b>Conceptualisation</b>	<b>Authors/Proponents</b>	<b>Measurement Indicators</b>
<b>WHO Quality of Life Framework</b>	An individual's perception/experience of his/her position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns.	World Health Organization  WHOQOL Group (1995b)	Physical health; psychological wellbeing; level of independence; social relationships; environmental elements
<b>Subjective wellbeing</b>	Subjective/perceived experiences of an individual's life/ individuals' subjective perceptions of their social environment.		Joy, pleasure, contentment, life satisfaction
<b>Level of living</b>	QoL is defined by control over resources such as money, property, knowledge, mental and physical energy, social relations and security. The individual is perceived as an active human being that uses his/her resources to pursue and satisfy basic interests and needs. Aimed at monitoring social change and trends, and to measure societal welfare.	Erikson (1993)	Objective social indicators – unemployment rate, wealth, income, household assets
<b>Capability Approach</b>	QoL is defined in terms of the capability of a person to achieve valuable functioning.	Sen (1993)	Good health, self-respect, life expectancy, literacy
<b>Having, Loving, Being</b>	QoL is based on meeting the 3 needs of having (material), loving (social) and being (personal growth).	Allardt (1993)	Combines subjective & objective indicators
<b>Integrative Quality of Life Model</b>	The extent to which objective human needs are fulfilled in relation to personal or group perceptions of subjective well-being.	Costanza <i>et al.</i> (2008)	Combines subjective & objective indicators

### **2.3 WHO Quality of Life Framework**

The World Health Organization Quality of Life (WHOQOL) framework is used in this study as a guiding framework for exploring quality of life, and is described in this section.

The World Health Organization Quality of Life (WHOQOL) framework is a holistic approach to assessing an individual's overall health and quality of life taking into account the individual's surroundings. The model was developed in response to 'the missing measurement in health', that is, the impact of disease and impairment on quality of life (WHOQOL Group, 1998). Furthermore, the WHOQOL model was developed to introduce a humanistic element to health care, reinforcing the importance of patient wellbeing, and moving away from the narrow approach of eradicating disease and symptoms (*ibid*). The WHOQOL model and tool were developed through a series of four stages:

- i) concept clarification, where an internationally agreed upon definition was developed;
- ii) qualitative pilot study, which involved the exploration of quality of life constructs across cultures and defining the facets;
- iii) the development pilot stage where the WHOQOL pilot form was administered across 15 culturally diverse field centres; and
- (iv) in the final stage, the WHOQOL tool was refined using data from the pilot stage (WHOQOL Group, 1998).



In this framework, quality of life is understood as “an individual's perception of his/her position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (WHOQOL Group, 1997:1). It is theorized that individuals move along a continuum of quality of life (Mweemba, 2008).

The WHOQOL framework was selected for use in this study because of its subjective approach that enables the exploration/understanding of quality of life from the perspective of children themselves. Unlike other theories and models that define quality of life from a population group perspective such as quality of life of a nation or a cultural group, the WHOQOL framework defines quality of life at an individual level. In addition, the framework places importance on the individual's perceptions as it explores his/her sense of satisfaction/dissatisfaction with various aspects that make up quality of life (Mweemba, 2008). Nonetheless, the model acknowledges that perceptions of adequacy vary greatly among people. Thirdly, unlike other quality of life theories, the WHOQOL model recognises the significance of culture and context; the model asserts that quality of life is embedded in a cultural, social and environmental context (WHOQOL Group,

1998). This enables an assessment of the effect of Zimbabwe's fragility on children's quality of life.

Although often used interchangeably, quality of life is distinct from health status, lifestyle, life satisfaction and wellbeing. Quality of life is much broader, as it incorporates an individual's physical health, psychological state, level of independence, social relationships, personal beliefs and other salient features, to the environment (WHOQOL Group, 1998). Each of these domains is comprised of elements that, individually and collectively, affect an individual's quality of life, as illustrated in table 2.2. These domains are interrelated, with each affecting the others. However, the framework does not clarify the nature of the relationships amongst the domains (WHOQOL Group, 1995b), and thus, the framework is descriptive in its approach. An overview of each domain is provided in table 2.2.

### **2.3.1 Physical Domain**

The physical domain encompasses an individual's ability to carry out activities necessary for life – this includes whether an individual is experiencing any pain or discomfort; the framework argues that a person's ability to manage and control pain affects his/her quality of life (WHOQOL Group, 1998). The framework acknowledges the differing responses, the tolerance and acceptance of pain across individuals. Whether an individual has enough sleep, rest and energy to perform daily tasks is also explored and considered contributory to quality of life (WHOQOL Group, 1995b). In particular, difficulty in falling asleep and waking up in the middle of the night, as well as the energy and enthusiasm a person has to perform daily living tasks are considered to affect one's quality of life. A person's physical wellbeing has a positive relationship with his/her quality of life; the higher the physical health status the better the quality of life (Sousa *et al.*, 1999 in Mweemba, 2008).

**Table 2.2 WHO Quality of Life domains**

<b>Domain</b>	<b>Composition</b>
Physical	An individual's ability to carry out activities necessary for life: <ul style="list-style-type: none"> <li>• Experiences of pain and discomfort;</li> <li>• Enough sleep and rest;</li> <li>• Energy to perform daily tasks.</li> </ul>
Psychological	An individual's emotional well-being: <ul style="list-style-type: none"> <li>• Feelings of depression, anxiety, despair and despondency;</li> <li>• Positive feelings of contentment, peace, happiness, hopefulness and joy;</li> <li>• Sense of self-worth;</li> <li>• A person's view of his/her thinking, learning, concentration, memory and ability to make decisions;</li> <li>• Relations with other people;</li> <li>• Satisfaction with one's body image and appearance.</li> <li>•</li> </ul>
Level of independence	An individual's mobility: <ul style="list-style-type: none"> <li>• Ability to get from one place to another;</li> <li>• Ability to perform daily living activities;</li> <li>• Dependence on medication/treatment;</li> <li>• Working capacity.</li> </ul>
Social relationships	An individual's social support and personal relationships: <ul style="list-style-type: none"> <li>• The extent to which one feels the companionship, love and support he/she desires in his/her life;</li> <li>• Support from family and friends.</li> </ul>
Environment	<ul style="list-style-type: none"> <li>• Financial resources;</li> <li>• Safety and security;</li> <li>• Availability and quality of health and social services;</li> <li>• Home environment - comfort, crowdedness, cleanliness, space available, privacy, dwelling structure, sanitary facilities;</li> <li>• Physical environment - noise, pollution, traffic and climate;</li> <li>• Opportunity to participate in recreation and leisure;</li> <li>• Transport accessibility.</li> </ul>
Spiritual, religious and personal beliefs	<ul style="list-style-type: none"> <li>• An individual's spiritual, religious and personal beliefs.</li> </ul>

### 2.3.2 Psychological Domain

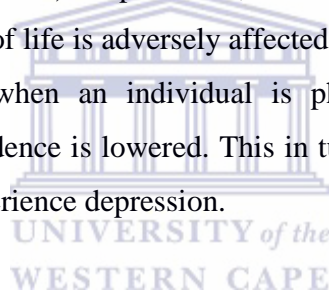
The psychological domain is largely made up of an individual's emotional wellbeing: this includes feelings of depression, anxiety, despair and despondency, as well as positive feelings of contentment, peace, happiness, hopefulness and joy. This domain also covers how a person feels about him/herself – that is, his/her sense of worth. The framework maintains that a person's view



of his/her thinking, learning, concentration, memory and ability to make decisions also contributes towards their quality of life. The domain explores how an individual gets along with other people; family relations and satisfaction with his/her body image and appearance. The framework argues that an individual's psychological wellbeing positively influences their quality of life and is a source of resilience against stress and illness (Mweemba, 2008).

### **2.3.3 Level of Independence**

This domain encompasses an individual's mobility; ability to perform daily living activities; dependence on medication/treatment; and capacity to work (WHOQOL Group, 1998). A person's ability to get from one place to another is assessed. The assumption in this model is that the degree to which people are dependent on others to help them in their daily activities is likely to affect their quality of life (WHOQOL Group, 1997). In particular, whenever a person's mobility is dependent on another person, his/her quality of life is adversely affected (*ibid*). This domain is affected by the physical domain; for example, when an individual is physically unwell and dependent on medication, their level of independence is lowered. This in turn affects the psychological domain, as a person may consequently experience depression.



### **2.3.4 Social Relationships Domain**

The social relationships domain consists of an individual's social support and personal relationships. This domain looks at the extent to which people feel the companionship, love and support they desire in their lives. Support from family and friends is also regarded as contributing to one's quality of life; in particular, the extent to which a person may depend on them in times of crisis. Also, Mweemba (2008) points out that humans need to feel a sense of belonging, and to feel loved. The facet of sexual activity looks at a person's urge and desire for sex, and the extent to which a person is able to express and enjoy this desire. The domain explores individuals' sex drive, sexual expression and sexual fulfilment (WHOQOL Group, 1997). In this study, the sexual activity facet is not included in the assessment, as the respondents are minors. In essence, this conceptual framework argues that if a person feels he/she is not receiving the support he/she requires, their quality of life will be adversely affected.



### **2.3.5 Environment Domain**

Factors in the environment domain that influence an individual's quality of life are financial resources; safety and security; availability and quality of health and social services; facilities in the home environment; the physical environment; participation in recreation and leisure; and transport accessibility. Financial resources are considered a facet of quality of life in view of the fact that what a person can or cannot afford contributes towards his/her quality of life. This facet focuses on an individual's view of how his/her financial resources meet the need for a healthy and comfortable lifestyle. A person's view of how his/her financial resources meet the needs of a healthy and comfortable life, and the extent to which they do so, influences his/her quality of life (WHOQOL Group, 1998). Satisfaction with one's income, regardless of amount and employment status, is important.

A person's sense of safety and security from physical harm contributes to his/her quality of life, because this bears directly on the individual's sense of freedom. This facet is particularly significant in this study's context of political unrest characterised by heightened violence and intimidation.

The health facet in this domain explores an individual's view of availability and quality of health and social services. Availability and quality of health services is an interesting measure in Zimbabwe's context of declining social welfare where (at the beginning of the study) most health and social services were suspended. This is an important facet in this study as it explores whether orphans feel they have access to adequate social protection services, which includes healthcare services as well.

Factors in the home environment that influence quality of life include an individual's dwelling, particularly characteristics such as comfort, crowdedness, cleanliness, space available, privacy, dwelling structure/material, sanitary facilities – water, toilet and electricity. In addition, the physical environment is one of the most important determinants of quality of life. An individual's surroundings – including such aspects as noise, pollution (water, land, and air), traffic and climate – contribute towards his/her health, thereby affecting the quality of life. The quality of the neighbourhood also influences quality of life.

The opportunity and ability to participate in leisure and recreational activities is also an important marker of quality of life. This model assesses an individual's perception of whether they feel they have the opportunities, and are able to engage in recreational activities. Children living in child-headed households – in many cases – are deprived of the recreational time associated with childhood as they have to assume adult roles and responsibilities of raising income, seeing to household chores and looking after younger siblings (Kurebwa and Kurebwa, 2014; Moffett, 2007; Nkomo, 2006).

An individual's access to transport services is important in determining quality of life; transport is vital for a person to perform the necessary tasks of daily living, as well as providing the freedom to perform chosen activities (WHOQOL Group, 1997). Modes of transport include car, bicycle, bus, train and commuter taxis.

### **2.3.6 Spirituality, Religion and Personal Beliefs**

A person's spiritual or religious beliefs and experiences are significant contributors to his/her quality of life (Mweemba, 2008). Religious beliefs may include Christianity, Buddhism, Islam, Hinduism, or not ascribing to any religious beliefs, including not belonging to any particular religious orientation (WHOQOL Group, 1998). According to the WHOQOL Spirituality, Religion and Personal Beliefs (SRPB) Group (2006), this domain explores an individual's inner peace, faith, hope and optimism because these contribute to his/her quality of life. The WHOQOL conceptual framework asserts that spirituality, religion and personal beliefs can confer comfort, security, a sense of belonging, purpose, strength and wellbeing for an individual (WHOQOL Group, 1997). In support of this, de Jager Meezenbroek *et al.* (2010) point out that spiritual orientation has the potential to help people cope with negative circumstances, such as life-threatening diseases. Spiritual, religious and personal beliefs have a strong correlation with psychological social wellbeing (WHOQOL SRPB Group, 2006).

### 2.3.7 Strengths and Weaknesses of the WHOQOL Framework

The WHOQOL framework was selected as a framework for this study because it offers several advantages over the other frameworks and approaches. Firstly, it is the only approach with cross-cultural and internationally developed tools to assess quality of life; the WHOQOL-100 and the WHOQOL-BREF have been validated in several countries around the world, including Zimbabwe, Thailand, India, Germany and Brazil. Secondly, as a framework, the WHOQOL model is holistic, and takes into consideration the different aspects that influence quality of life. Thirdly, this model understands that things that satisfy and determine quality of life differ from individual to individual; for example, while one individual may regard financial and material resources as crucial in enhancing quality of life, another individual might regard social relationships as contributing the most towards quality of life. With this in mind, the WHOQOL model seeks to understand quality of life from the individual's perspective.

The WHOQOL framework also has its weaknesses. Firstly, it is descriptive and explanatory in nature, and fails to show how factors influence quality of life. For example, it fails to show how dissatisfaction with social relationships affects an individual's quality of life. Secondly, the framework does not elaborate on the correlations between domains; for example, it does not indicate whether there is a relationship between the environmental and the psychological domains. Thirdly, the framework lacks three particular elements that influence quality of life:

- i) food security;
- ii) material goods such as clothing and toiletries;
- iii) educational attainment or access to education.

Food security is recognised as an important determinant of health (McIntyre, 2003) and the lack of it has an impact on an individual's nutrition, physical health and mental well-being (Carter *et al.*, 2011). Thus, food security is critical and contributes towards one's quality of life. The WHOQOL questionnaire indirectly incorporates food security in questions relating to affordability and having enough money to meet basic needs. Such an approach assumes that food security is influenced by financial resources, which is not necessarily the case, as factors such as drought, famine and commodity shortages at the national level may affect a person's ability to acquire food resources. This was made evident during Zimbabwe's macro-economic collapse between 2008 and 2011,

where people had money but there were no commodities to purchase (Makochekanwa and Kwaramba, 2009).

The framework also does not consider an individual's level of education which Sen's Capability Approach argues is essential to an individual's wellbeing. Educational attainment also influences quality of life as it is an indicator of life outcomes such as social status, employment and income (ESRC, 2014). Several studies have shown the effect of education on health, happiness and mental wellbeing (ESRC, 2014). Quality of life is influenced through satisfaction or dissatisfaction with one's educational levels and feelings of self-attainment. Furthermore, education is instrumental in shaping social identity, as educational levels may affect an individual's social standing in his/her community, with the lack of it causing low self-esteem and feelings of worthlessness (ESRC, 2014).

## 2.4 Determinants of Health Model

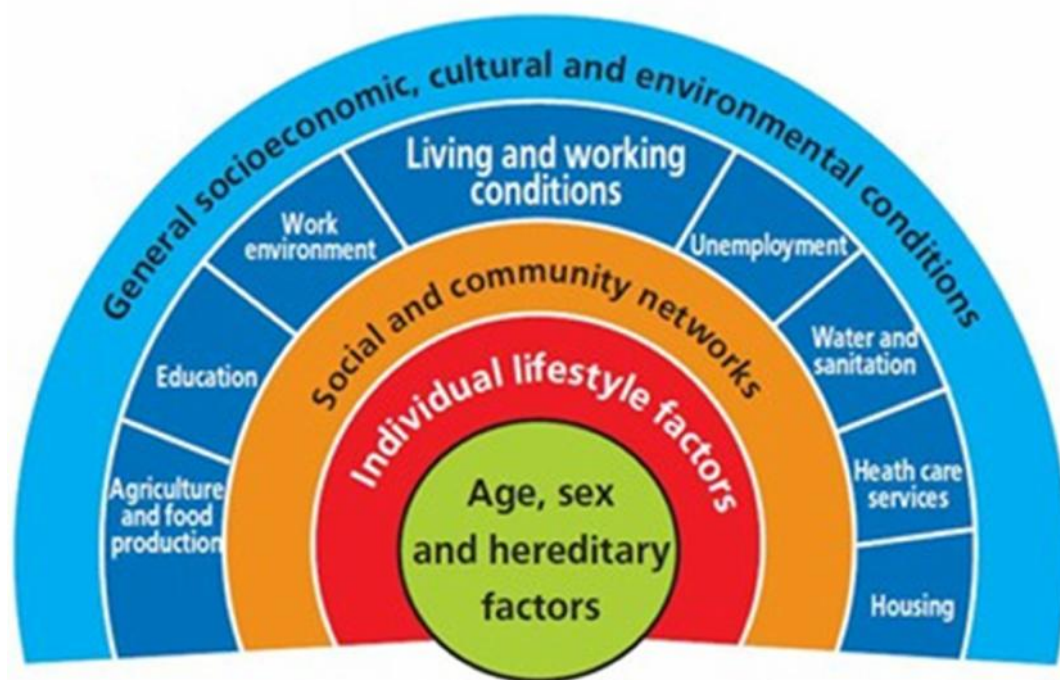
The Determinants of Health model was used to complement the WHOQOL framework in conceptualising the quality of life of child-headed households. The model was developed by Dahlgren and Whitehead to improve understanding of the distinct influences on health (Dahlgren and Whitehead, 1991). The conceptual framework aims to improve health and reduce health hazards by suggesting levels of policy intervention (*ibid*). Unlike the WHOQOL framework, this model takes a social ecological perspective going beyond the analysis of individual and environmental factors, and focusing on how structural factors influence individuals' health and well-being. Most population health approaches neglect the role of political and economic forces in understanding the quality of social determinants (Raphael and Bryant, 2006; Commission on Social Determinants of Health (CSDH), 2007). As a result, these factors have been understudied.

This model asserts that the health and wellbeing of individuals is influenced by a range of factors or determinants which threaten, promote or protect an individual's health. Determinants of health are factors that influence health either positively or negatively (Dahlgren and Whitehead, 1991). These factors can be categorised into four levels:

- i) socio-economic, cultural and environmental conditions;

- ii) living and working conditions;
- iii) social and community networks; and
- iv) individual lifestyle factors.

These levels are interdependent, and any health and wellbeing challenge can be addressed at any of the four levels. Dahlgren and Whitehead (1991) developed an illustrative model (figure 2.1) with a series of layers of these factors, one on top of the other.



**The Determinants of Health (1992) Dahlgren and Whitehead**

**Figure 2.1 Determinants of Health Model**

**Source:** Dahlgren and Whitehead (1991)

### **2.4.1 Determinants of Health Domains**

#### *Personal Factors*

Personal characteristics such as age, sex and ethnicity are the determinants of health that are nested within the wider determinants of health (Whitehead, 1995). These are the core factors and

are non-modifiable, with little or no control over them in terms of interventions. Although the model correctly identifies personal factors affecting health, it does not describe *how* these factors operate to affect health.

#### *Individual Lifestyle Factors*

The second layer is individual lifestyle factors, which are lifestyle choices that individuals make, such as smoking, diet and food choices, and frequency of physical activity. Interventions at this level would be aimed at influencing individual lifestyles and attitudes, for example, health education interventions (Dahlgren and Whitehead, 1991).

#### *Social and Community Networks*

This layer consists of support from family, friends, neighbours and the community at large. Social and community networks have a protective influence on an individual's health and wellbeing, with the lack of this support consequently having a threatening effect. This level recognizes the intrinsic strengths of families, friends and communities over the capabilities of individuals. Consequently, the model advocates for interventions that strengthen family and community support.

#### *Living and Working Conditions*

These are the material and social conditions in which people live and work (Dahlgren and Whitehead, 1991). These conditions include an individual's access to opportunities and facilities in relation to employment, education, housing, health, food security and welfare. These factors can be addressed at national, regional or local level, with social protection interventions through social security, health care, agricultural and labour sectors (Dahlgren and Whitehead, 1991).

#### *Socio-economic, Cultural and Environmental Conditions*

Structural factors include availability of work, wages, the prices of commodities, and taxation. According to the model, these factors are addressed at national and international levels.



#### **2.4.2 Strengths and Weaknesses of the Determinants of Health Model**

This is the most recognised and widely used model on determinants of health. The model is holistic and incorporates all the levels – macro, meso and micro levels that influence a person’s health and quality of life. Importantly, the model identifies upstream (macro-level) factors as very influential on quality of life (Canadian Council on Social Determinants of Health, 2015). However, although this model shows the layers of influence, it does not show the interactions between these layers, for example, how living and working conditions influence individual lifestyle factors.

### **2.5 Summary**

Quality of life is a ubiquitous concept with no single agreed upon definition. This chapter unpacked the concept of quality of life and determinants of health, and discussed the various approaches to defining these. This study employs the WHOQOL framework and the Determinants of Health ecological framework to conceptualise quality of life and the factors that influence it. The WHOQOL framework views quality of life as a subjective perception embedded in an individual’s cultural, social and environmental context. The framework posits that quality of life is made up of one’s physical wellbeing; psychological state; social relationships; level of independence; spiritual, religious and personal beliefs; as well as salient features of the environment. This framework, however, does not incorporate macro-level factors. The Determinants of Health model complements the WHOQOL framework, by employing a social ecological perspective to quality of life. In the model used in this study, the determinants of health are: i) socio-economic, cultural and environmental conditions; ii) living and working conditions; iii) social and community networks; and iv) individual lifestyle factors.

These two frameworks provide an analytical lens for the study. The next chapter discusses existing literature on previous studies on the experiences of orphans and the establishment of child-headed households.

## CHAPTER THREE

### LITERATURE REVIEW

#### 3.1 Introduction

Children who have lost one or both parents are vulnerable and often experience challenges such as psychological distress, stigma, social isolation, food insecurity, physical and sexual abuse, exploitation, poor health outcomes and may drop out of school. In addition to these challenges, orphans may fail to be absorbed by relatives leaving them to live as child-headed households. The vulnerability of orphans living in these child-headed households is further exacerbated by the absence of an adult guardian, as these orphans are left to assume parental, caregiving and livelihood responsibilities.

This chapter begins with a discussion of the challenges experienced by orphans and how they transition into child-headed households. A critical review of previous studies on the experiences and factors influencing the wellbeing of children living in child-headed households is presented, highlighting children's vulnerability and resilience.

#### 3.2 Orphans

An orphan is defined as a child who has lost one or both parents (UNAIDS, UNICEF and USAID, 2004). These orphans are referred to as maternal, paternal or double orphans. Maternal orphans are children who have lost their mother while paternal orphans are those who have lost their father. Double orphans are children who have lost both parents (Francis-Chizororo, 2008). Globally, there are over 140 million orphans (UNICEF, 2016). In sub-Saharan Africa HIV/AIDS is the leading cause of orphanhood accounting for 83% of the global total of 13.3 million children who have been orphaned by HIV/AIDS (*ibid*). The situation of orphans in the region has often been referred to as a “ballooning crisis” owing to the growing number of orphans; it is estimated that the number of orphans has grown from less than 1 million in 1990 to 11 million in



2014 (MacLellan, 2010). These numbers are likely to increase as a result of the long incubation period of the infection (Gregson, Garnett and Anderson, 1994; Whiteside *et al.*, 2003 in Watts *et al.*, 2007). This crisis is well documented (Foster *et al.*, 1995; Foster, 2000; Foster, 2002; UNICEF, 2003; UNICEF, 2016; MacLellan, 2010).

### 3.2.1 Challenges Experienced by Orphans

The effect of orphanhood varies across the different age groups – infant, young child, adolescent (UNAIDS *et al.*, 2004 in Francis-Chizororo, 2008). Francis-Chizororo (2008) argues that orphanhood is a process that begins well before parents pass away and extends beyond adolescence. There are also differences in the vulnerability between maternal orphans and paternal orphans (*ibid*). It is well documented that orphans experience numerous challenges which include: i) food insecurity; ii) educational challenges; iii) psychological distress; iv) poor health outcomes. These challenges are discussed in turn.

#### *i) Food Insecurity*



Children orphaned by HIV/AIDS are particularly vulnerable to food insecurity as a result of lost income, prolonged illness and the loss of a parent. They are likely to be absorbed into a poor household (Case *et al.*, 2004; UNICEF, 2003; Madhavan and Townsend, 2007 in Kimani-Murage *et al.*, 2011). It is documented that children usually experience food insecurity before becoming orphans. Households affected by HIV have been shown to experience greater vulnerability to food insecurity as income and manpower for agricultural production decline, while medical costs and caregiving responsibilities increase (de Waal and Whiteside, 2003; Gillespie *et al.*, 2004; Barnett and Blaikie, 1992; Bukusuba *et al.*, 2007). Research has shown that these households affected by HIV/AIDS experience a drop, in food consumption of up to 40% (Topouzis, 1999 in Bukusuba *et al.*, 2007). De Waal and Whiteside (2003) highlight the effect of HIV/AIDS on household food security in Malawi. Funeral ceremonies often drain the few financial resources left leaving orphans in poverty (Audemard *et al.*, 2006).

After parental death, food insecurity persists, as orphans are likely to be absorbed into poor households or remain as child-headed households with no income. Furthermore, households that absorb orphans experience an increase in household size, which may reduce food quantities.

Research corroborates this in a study in Tanzania, where orphans were more likely to go to bed hungry than non-orphans (Makame *et al.*, 2002). Similarly, Kimani-Murage *et al.*'s study (2011) found orphans living in households in informal settlements to be more vulnerable to food insecurity than non-orphans.

Although the relationship between orphanhood and food insecurity is clear, there is no evidence that this translates into poor nutrition as several studies have found no significant correlation between the two (Kimani-Murage *et al.*, 2011; Sarker *et al.*, 2005; Lindblade *et al.*, 2003; Rivers *et al.*, 2004).

### *ii) Educational Challenges*

Despite the right to education being a fundamental right for all children, their enrolment, attendance and performance are all affected by poor health, poverty, psychological distress, hunger and inadequate resources. Important to note is that this relationship between orphanhood and school attendance/enrolment is influenced by factors such as age, gender, household composition and orphan type – maternal or paternal (Ainsworth *et al.*, 2005). Older children are likely to drop out and work, while girls are more likely than boys to drop out of school to look after a sick parent (Francis-Chizororo, 2008). Younger children may fail to enrol in school after parents pass away. In Pufall *et al.*'s study (2014), young carers were less likely to attend school compared to other children.

Furthermore, some orphans are HIV positive themselves and illnesses may affect their school attendance and performance (Pufall *et al.*, 2014). Pufall *et al.* point out that perinatal HIV infection can impact children's cognitive development which could negatively affect their school performance. Pufall *et al.*'s study did not, however, show the effects of HIV status on education outcomes.

Literature has shown that the majority of orphans live in conditions of poverty. Children may be absorbed by poor relatives, who may not afford to keep them in school. Relatives may not be able to take all the children in the household to school, and often choose their biological children over fostered orphans. Ainsworth and Filmer (2002 in Francis-Chizororo, 2008) indicate that as a result of poverty, orphans are likely to have lower school enrolment rates compared to non-

orphans. Relatives may also be unwilling to send orphans to school (Matchalaga, 2002), exploiting them rather as domestic and livelihood labour. In an urban community in Zimbabwe, 72% of children affected by HIV/AIDS were out of school compared to 29% of children not affected by HIV/AIDS (Kembo, 2010 in Pufall *et al.*, 2014). Similarly, in Nyamukapa and Gregson's study (2005) in Zimbabwe, orphans were less likely to have completed primary school compared to non-orphans.

The performance of orphans is also affected by frequent absenteeism, poor concentration arising from psychological distress, hunger and inadequate resources such as textbooks. The psychological trauma of nursing an ill parent and watching them die, greatly affects children's psychological wellbeing and mental functioning (Makame *et al.*, 2002; Richter *et al.*, 2004). This in turn affects their school performance. In Pufall *et al.*'s study (2014), orphans were also less likely to be in their correct grade because of disruptions. Several studies confirm this (Ainsworth *et al.*, 2005; Bicego *et al.*, 2003; Kasirye and Hisali, 2010 in Pufall *et al.*, 2014). Evidence suggests that maternal orphans are more likely to have their education disrupted than paternal orphans as girls are more likely to take up caregiving responsibilities such as looking after siblings, cooking and other household chores (Bicego *et al.*, 2003; Ardington and Leibbrandt, 2010).

Literature suggests that children's performance and attendance is compromised by household food insecurity in two ways. Firstly, when children are hungry and malnourished, their energy and concentration levels are low and their cognitive and mental skills are poorly developed. Malnutrition also increases children's susceptibility to illness thereby increasing absenteeism and affecting children's performance. Several studies have shown that malnourished children are more likely to start school later and drop out, compared to healthier children (Alderman, Hoddinott, and Kinsey, 2003; Behrman, 2000; Behrman *et al.*, 2003; Glewwe, Jacoby, and King, 2001; Grantham-McGregor *et al.*, 2007). Secondly children miss school to engage in food production activities (Belachew *et al.*, 2011; Masset and Gelli, 2013; Jomaa *et al.*, 2011; FAO, 2005). The Food and Agricultural Organisation of the United Nations (2005) points out that hungry children start school later, drop out sooner and are more likely to be absent and learn less when they do attend. This is the premise of school feeding programmes as they aim to reduce absenteeism and drop outs and increase performance.

### *iii) Psychological Distress*

Several studies have shown the association between orphanhood and psychological distress (Cluver and Gardner, 2007a; Nyamukapa *et al.*, 2008; Nyamukapa *et al.*, 2010; Doku, 2009; Pufall *et al.*, 2014; Makame *et al.*, 2002). The experiences of orphans predispose them to psychological distress (Makame *et al.*, 2002). In particular, having to care for a sick parent and eventually watch them die is distressing and can have long term psychological effects (Richter *et al.*, 2004). In the case of HIV, children often experience multiple bereavements as one parent dies after the other (Sherr *et al.*, 1992; Richter *et al.*, 2004; Korevaar, 2009). As a result, orphans are likely to experience episodes of anxiety, loneliness, anger, confusion and long-term grief (Korevaar, 2009; Cluver *et al.*, 2007; Foster, 2006). Masondo (2006) maintains that children's psychological distress begins during their parents' illness. Cluver and Gardener (2007b) however argue that there is little evidence for parental bereavement as a risk factor for psychological problems in children. In their systematic review, Cluver and Gardener (2007b) also found no differences in externalising problems amongst children orphaned by HIV in comparison to other orphans.

As mentioned earlier, once parents die, children are taken in by the extended family and in many cases, they are split between relatives. This separation can be devastating as siblings may provide children with a sense of comfort and stability, which is destroyed by their separation. Furthermore, relocation to a new area, family and school as well as leaving friends behind can also affect children psychologically (Makame *et al.*, 2002;). Children may also experience inadequate guardian supervision and support as well as frequent changes in guardians (Nyamukapa *et al.*, 2010). Foster *et al.* (1997) point out that the combination of these stressors will negatively affect children's psychological wellbeing.

Orphans also experience psychological distress such as depression as a result of being stigmatised by communities, relatives and by peers (Atwine *et al.*, 2005). During a parent's illness and after death, children are often stigmatised resulting in social isolation, which could translate into loneliness and low self-worth.

In a study in Zimbabwe, orphans showed higher levels of psychological distress in comparison to non-orphans (Nyamukapa *et al.*, 2010). Nyamukapa *et al.* (2008) developed a theoretical

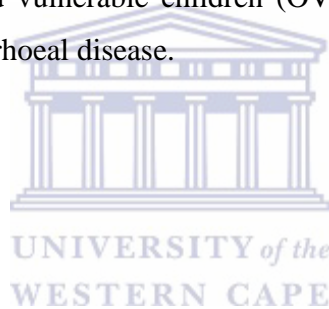
framework that hypothesises the causes and consequences of psychosocial distress amongst children orphaned by HIV/AIDS. This framework posits that the determinants of psychosocial distress are illness and death related trauma, relocation, separation from siblings, residing in the poorest quintile households, inadequate care, not enrolled in school, child labour and physical abuse (*ibid*). Some of these determinants, such as parental death is immediate, causing psychosocial distress in a short space of time, while other determinants such as child labour and dropping out of school are gradual and may affect children over a long time. Social contexts also inhibit or facilitate the development of psychosocial distress amongst orphans (Nyamukapa *et al.*, 2008). According to the theoretical framework, the consequences of psychosocial distress include chronic trauma, poor mental and physical health, dropping out of school, risky behaviour, and chronic illnesses including HIV infection.

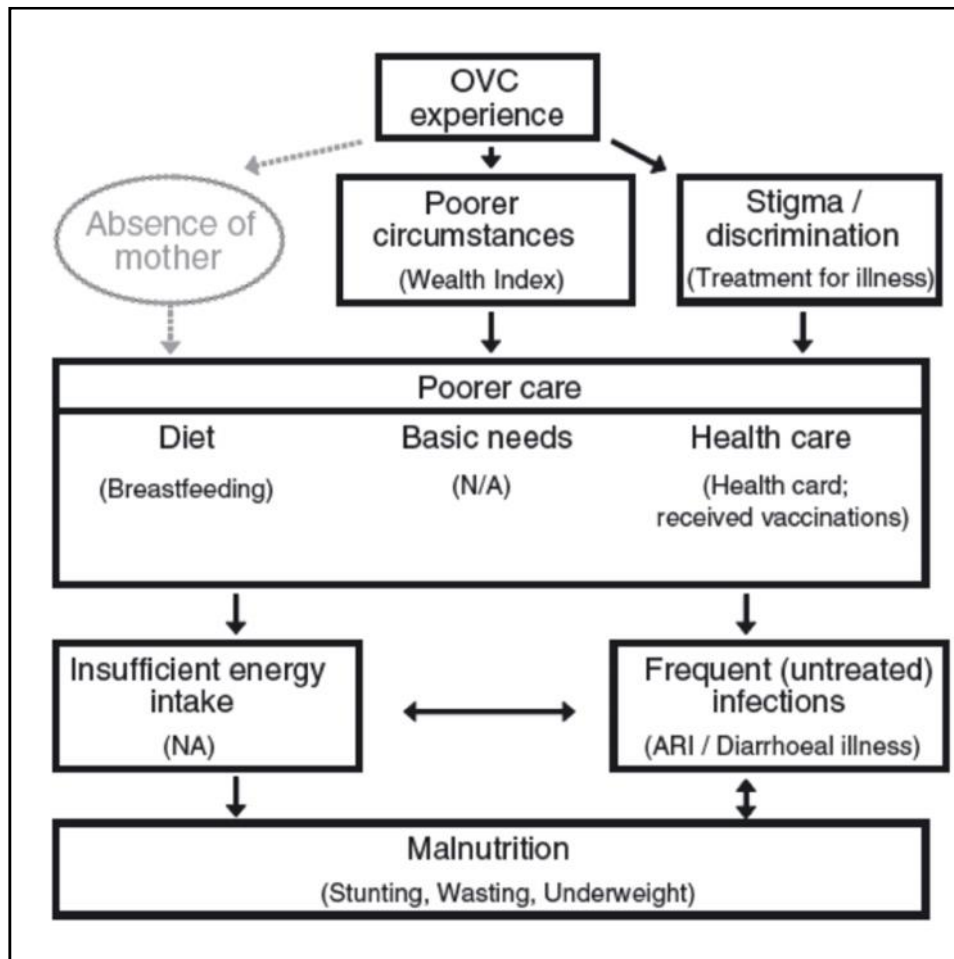
Using the Strengths and Difficulties Questionnaire (SDQ), Doku (2009) surveyed 50 children orphaned by HIV/AIDS, 51 children orphaned by other causes, 48 children living with parents with HIV and 51 non-orphaned children in Ghana. Orphanhood and parental HIV/AIDS were found to be associated with increased internalising of problems and problems with peer relationships. These findings are consistent with findings from Tu *et al.* (2010 in Pufall *et al.*, 2014) that showed orphans to be less confident and more anxious, aggressive and impulsive compared with non-orphans (*ibid*). Furthermore, Doku's findings confirm that the impact of HIV/AIDS on children starts before they become orphans, as 43% of children living with parents that are HIV positive showed abnormal emotional problems compared to 40% of children orphaned by HIV/AIDS. Orphans reported behavioural problems such as stealing and fighting.

Cluver and Gardner's study (2007) in South Africa identified risk and protective factors for the psychological wellbeing of children orphaned by HIV/AIDS. Risk factors identified were multiple bereavements, stigma, poverty, food insecurity, multiple moves, changes in caregivers, family conflict, abuse and lack of medical care. Protective factors were supportive friends, attending school, contact with extended family, being loved and respected and the presence of a caregiver. These findings are consistent with findings in the literature.

*iv) Poor Health Outcomes*

The Commission for Social Determinants of Health indicates that factors influencing an individual's health include income, living conditions, social support, education and health literacy, individual behaviour and lifestyle factors, as well as access to health care (WHO Commission on Social Determinants of Health (CSDH, 2008; SACOSS, 2008). A combination of these challenges consequently compromises children's health. Watts *et al.* (2007) developed a theoretical framework (Figure 2.2) that outlines the relationship between orphanhood and malnutrition. This theoretical framework posits that orphans are likely to reside in poorer households, and will therefore experience poor childcare, manifesting as poor diets, inadequate healthcare and unmet basic needs of housing, clothing and education. This in turn results in poor health, malnutrition and weakened immune systems (Watts *et al.*, 2007). In their study, Watts *et al.* (2007) found that orphans and vulnerable children (OVCs) were significantly more likely than their peers to suffer from diarrhoeal disease.





**Figure 3.1 Hierarchical framework for investigating the causal pathways between OVC experience and ill-health and malnutrition.** Source: Watts *et al.* (2007)

### 3.3 Orphans Living in Child-headed Households

The extended family has traditionally been the social security system caring for vulnerable, poor and sick relatives in Africa (Foster *et al.*, 1997). It continues to be the principal orphan care unit whereby orphans are taken in by grandmothers and relatives after the death of their parents. Literature also shows that children are fostered by relatives, even before becoming orphans, and are taken in by relatives when parents become ill. Thus, the concept of a “social orphan” – a child with no guardian – did not exist in Zimbabwe as paternal and maternal aunts and uncles assumed parental roles when biological parents passed away (Foster *et al.*, 1997). Sherr *et al.*



(2014) indicate that 90% of orphans in HIV infected countries live with their extended family. This child fostering strategy is crucial in African families (Madhavan, 2004).

However, with the advent of the HIV epidemic, traditional orphan care strategies have changed (Francis-Chizororo, 2008). Over time and as societies evolve this social security system has been weakened by migration, urbanisation and westernisation (Foster, 1997). Social and economic independence arising from migration and urbanisation has reduced contact between relatives, weakening the links between families. High morbidity and mortality as a result of HIV/AIDS has increased the extended family's burden, as they look after sick parents and foster their children when they die. In addition, economic hardships have reduced the extended family's capacity to provide and care for orphans; the traditional value of children has reduced, as a result of the declining agricultural economy; previously, children were an asset providing additional labour force, now they are regarded as a burden, i.e. an extra mouth to feed (Francis-Chizororo, 2008). Consequently, the extended family is increasingly becoming overstretched, leaving many orphans to live on their own as child-headed households (Francis-Chizororo, 2008; Foster *et al.*, 1997; MacLellan, 2010).

This concept of child-headed households represents a significant change in the conventional and traditional patterns of orphan care (Evans, 2010). To fully comprehend this phenomenon, it is imperative to begin with a definition of a household. Statistics South Africa defines a household as consisting of people who have stayed in a common dwelling for an average of at least four nights a week (Meintjes *et al.*, 2010). With this definition in mind, a child-headed household can loosely be understood as a household, as described above, where the head is below 18 years of age. Bequele (2007) defines a child-headed household as “a household run by children younger than 18 who have lost both parents or whose parents or primary caregivers are (chronically) ill” (2007: 3) while van Dijk (2008: 242) gives a more elaborate definition: “a household consisting of one or more young people, legal or social minors, of whom one or more have taken on adults' caring tasks for themselves and/or others and who are not eligible for formal support, or lack the means to access support”.

However, defining child-headed households is much more complex, as the concept has been widely debated. This has resulted in numerous types and classifications of child-headed households, based on household head's age, relationship of children as well as the presence or



absence of an adult member. Some definitions emphasise siblings living together, for example Mkhize's definition describes it as "a unit constituting of siblings who are children, in which the caring role is to be performed by one or more of these siblings" (2006: 14). Similarly, the UN Guidelines for the Alternative Care of Children (UNICEF, 2009b, Paragraph 37) refer to child-headed households as "a living arrangement consisting of two or more siblings who have lost their parents or other caregivers, in which no adults are present; the eldest child is to be both willing and deemed capable of acting as the household head". Phillips (2011), however, cautions against the use of the term "siblings" when referring to child-headed households, as they do not necessarily consist of siblings only but also of children with no blood ties. This can be seen in Luzze's study (2002) in Rakai, Uganda where some child-headed households were composed of cousins and others included children who were unrelated. Evans (2010) proposes the use of a more inclusive term, *sibling-headed households* when referring to child-headed households composed of siblings only.

Furthermore, Phillips (2011) argues that child-headed households do not always consist of more than one child, pointing out that a household, where a child lives alone, is also a child-headed household. In light of all these considerations, Phillips (2011:163) proposes that a child-headed household be defined as "a household consisting of one or more members, in which the role of principal caregiver has by necessity been taken over by a child under the age of 18". This definition is broader and accommodates sibling and non-sibling child-headed households as well as child-headed households with incapacitated adults.

Another complexity in defining child-headed households is the age of the household head, as authors differentiate between a child-headed household, an adolescent-headed household and a youth-headed household. In a child-headed household, the household head is between the ages 0 - 13 years while in an adolescent-headed household the head is between 14-17 years of age (Sloth-Neilsen, 2004). Once the child head reaches 18 years, the household is then referred to as a youth-headed household (Phillips, 2011; African Child Policy Forum, 2010). These terms are interchangeable, as the definition of a child includes minors up to the age of 18 years so therefore, adolescent-headed households can be considered child-headed households.

Having defined child-headed households, researchers/authors go on to differentiate types of child-headed households. Firstly, child-headed households are categorised based on the presence

or absence of adults. Bequele (2007) points out that some child-headed households may include an incapacitated adult who may also be bed-ridden, physically or mentally challenged, debilitated, blind or old, and thus the oldest child assumes the role of household head. Hence the African Child Policy Forum categorises this type of child-headed household as an “accompanied” child-headed household, as an adult is present but not able to carry out the expected adult responsibilities being themselves in need of care. On the other hand, “unaccompanied” child-headed households consist solely of minors below the age of 18 years with no adults present. The current study specifically focuses on these unaccompanied child-headed households.

Another category of child-headed households as proposed by Human and Van Rensburg (2011) is that of “supported” and “unsupported” child-headed households, with the former receiving some form of regular support. Support is provided by structures such as extended family members, neighbours and community structures. These two categories are not mutually exclusive as a child-headed household can be unaccompanied and supported, meaning the household has no adults present but receives external support from relatives and the community.

### **3.3.1 Prevalence of Child-headed Households**

The first cases of large numbers of child-headed households were reported in the early 1990s in Uganda, then in Tanzania, Zambia and Zimbabwe (Bequele, 2007). There is a dearth of accurate and reliable data/statistics on the number of children living in child-headed households in various countries across sub-Saharan Africa. MacLellan (2010) alludes to the challenges in obtaining statistics on the prevalence of child-headed households. In her study, MacLellan (2010) shows the variations in child-headed household statistics across sources. These variations may be attributed to methodological flaws. In particular, cross-sectional surveys, with single household visits may be misleading, as child-headed households may exist temporarily when children are left alone for a short period (MacLellan, 2010). The different definitions and typologies of child-headed households discussed earlier also complicate efforts to estimate the number of child-headed households in Southern Africa let alone, sub-Saharan Africa. This may lead to under- and over-estimations of the number of child-headed households. In addition, child-headed households are generally a hard-to-reach and “invisible” population group, as these children are

highly mobile and hardly at home (Francis-Chizororo, 2009). Phillips (2011) also points out that communities' denial of the existence of child-headed households makes them difficult to count. Furthermore, statistics on child-headed households are often lacking in demographic household surveys, as most of the time respondents are required to be adults.

### **3.3.2 Factors Influencing the Establishment of Child-headed Households**

Previously, child-headed households formed as a temporary arrangement, when parents or grandmothers passed away or moved in with relatives. They would dissolve once alternative care arrangements had been made, such as moving in with relatives or a care institution (Foster *et al.*, 1997; Hosegood *et al.*, 2005; MacLellan, 2010). In recent years, however, these household structures have become permanent features, representing a new type of household and family arrangement. Literature points to numerous factors influencing the formation of these household types, which include: (i) the inability and unwillingness of the extended family to foster orphans (Ntozi *et al.*, 1995; Foster *et al.*, 1997; Foster and Williamson, 2000; Makame *et al.*, 2002; Hope, 2005; Dalen, 2009); (ii) weak family networks (Foster, 2000; Alpaslan and Nzinyane, 2011; Mabvurira *et al.*, 2012; Kurebwa and Kurebwa, 2014) (iii) overstretched alternative care institutions (Phillips, 2011); and (iv) children opting to live alone (Francis-Chizororo, 2009). This section extensively discusses the factors above that lead to the formation of these households.

#### *i) Inability and Unwillingness of the Extended Family to Provide Care*

The extended family, the principal orphan care unit in African communities, has been stretched and as a result many families lack the capacity to take in or support more orphans (Dalen, 2009). The extended family is a network of connections extending through varying degrees of relationship over a wide geographic area (Foster, 2000). Traditional African communities are built around the kinship system with the extended family providing security and support to all its members and particularly to the vulnerable, poor and sick. This structure has been in existence in the African setting long before the AIDS era, and has been used as a safety net in response to social and economic stresses throughout sub-Saharan Africa (Foster *et al.*, 1997). Children are often sent to live with relatives so as to reduce the economic burden on the sending household

and when a parent/guardian dies, the extended family absorbs the orphaned children (MacLellan, 2010). However, there is increasing evidence that the integrity, cohesion, capacity and efficacy of these social support networks are being undermined by a range of factors which include the HIV/AIDS epidemic, poverty, over-stretched resources and rapid urbanisation (Nelson Mandela Children's Foundation, 2001; Hope, 2005; Dalen, 2009; UNAIDS, 2004).

The HIV epidemic has placed an immense burden on the extended family which takes on the financial, caregiving and child fostering responsibilities (Foster and Williamson, 2000). In particular, the high mortality rates have led to a ballooning orphan crisis, burdening the extended family, as more than 90% of orphaned children in most sub-Saharan African countries are cared for by extended families (UNICEF, 2003). Many households have therefore been stretched and are unable to take in any more children. As Foster (2004) correctly points out, the extended family is not a social sponge with infinite capacity to soak up orphans. Consequently, these orphans are left to live on their own, forming child-headed households.

Poverty and economic instability have also diminished the extended family's ability to support orphaned children (MacLellan, 2010). Relatives, particularly unemployed relatives, may be financially limited and lack sufficient resources to adequately support additional children; these households are already struggling and taking in more children becomes an additional burden reducing their standard of living (Deininger *et al.*, in Miller *et al.*, 2006; Makame *et al.*, 2002; Ntozi *et al.*, 1995). Monk (2000) indicates that when orphans live with non-orphans they confer their hardships of reduced resources and living space onto non-orphans. This is evident in a study by Alpaslan and Nziyane (2011) where the inability to provide food and clothing prevented relatives from taking in orphans. Similarly, in a study in Uganda and Tanzania, orphans were left to form youth-headed households as relatives indicated they had their own children to care for and could not take in more children (Evans, 2010). These relatives may prefer to support orphans without taking them into their homes (*ibid*). This way, relatives feel they are not obligated to meet children's every need; instead they will, according to their ability, support them where possible.

Furthermore, lack of sufficient housing and living space inhibits relatives from fostering orphaned children. In many poor communities, housing structures are very small and often cannot accommodate large families. Relatives may not have extra room and space to

accommodate orphans, and are therefore unable to absorb them, leaving them to form child-headed households (Alpaslan and Nziyane, 2011). This is evident in a study in Zimbabwe where relatives had no space in their homes to accommodate orphans (Foster *et al.*, 1997). In some instances, an adult relative may move into the orphans' house.

Relatives may also be unwilling to absorb orphaned children. In Foster's study, 88% of child-headed households were formed as result of relatives not wanting to care for orphans (Foster *et al.*, 1997). This was also evident in a study in Tanzania and Uganda, where relatives refused to take in children after their parents passed away (Evans, 2010). Several reasons may influence the extended family's unwillingness to foster orphans. Some relatives may be reluctant to foster a child whose parents died of HIV and may also be HIV positive, as they fear contracting the virus (*ibid*). This was particularly the case in the early 1990s, with the onset of the epidemic, when HIV and its mode of transmission was surrounded by stigma and not well understood. Relatives may also refuse to foster orphans as they are unwilling to take up the responsibility, owing to the extra care and support, in terms of treatment, nutrition and psychosocial dynamics, required for a child living with HIV (Maqoko and Dreyer, 2007).

Furthermore, some relatives may fear being stigmatised by the community after absorbing a child who is living with HIV or whose parents died of HIV/AIDS related illnesses (Foster *et al.*, 2004). In many cases, relatives prefer visiting and providing material support to orphans in child-headed households, rather than living with them. Evidence from Zimbabwe also shows that relatives often preferred not to take the orphans in but to support them while they continued to live at their parent's home (Foster *et al.*, 1997; Germann, 2005b). This is how "supported child-headed households" are established - the extended family is unable or unwilling to live with the children but still provides a certain amount of caregiving, material and psychosocial support to the children.

Past conflict between deceased parents and relatives can also be a barrier to orphans being absorbed by relatives. Literature shows that long-standing family disputes prevent relatives from fostering orphans (Alpaslan and Nziyane, 2011; Nkomo, 2006; Foster *et al.*, 1997). These disputes weaken extended family relations, reducing the sense of obligation to foster a deceased relative's children. In addition, weak ties due to conflict may also result in poor communication

between families, and therefore the extended family may be unaware of the existence and situation of the child-headed households.

Child-headed households also form when the patriarchal relatives refuse to take in orphans born out of wedlock (Alpaslan and Nziyane, 2011). Most African cultures are built around patrilineal kinship systems and children belong to the father's family and not the mother's. However, only children born after the bride price payment has been initiated are recognised as "legitimate," becoming the responsibility of the paternal family. Those born out of wedlock (prior to bride price payment) are considered "illegitimate" (Foster, 2000:56). When parents pass away, patriarchal relatives may therefore refuse to foster these "illegitimate" children. The maternal aunts are also restricted as these children do not belong to their (maternal aunts) husbands' patrilineage and they are thus not able to take them into their husband's home. This is evident in Alpaslan and Nziyane's study (2011), where matrilineal relatives could not foster orphans, leaving them to form child-headed households.

#### *ii) Weak Family Networks*

Urbanisation has weakened extended family networks. Firstly, traditional kinship obligations have become more relaxed and the practice of orphan inheritance, in particular, has decreased (Kurebwa and Kurebwa, 2014). Relatives therefore are not obligated to take in orphans and may choose to leave them as child-headed households. Secondly, relatives are spread out within the country and abroad, and as a result relationships have weakened and families have lost contact (Foster, 2000; Alpaslan and Nziyane, 2011). In some cases, children do not know any of their extended family. As a result, when parents die, orphans end up living on their own as they may fail to locate their relatives, leaving them with nowhere to go and no one to whom they can turn. In Foster *et al.*'s study, (1997) of factors leading to the establishment of child-headed households, 13 households were formed, as a result of there being no known relatives to absorb these orphans. This is particularly evident in migrant communities, and children of second and third generation migrants, who are disconnected from their extended family (Dalen, 2009). For example, Zimbabwe has a considerable population of second and third generation families, originally from Malawi and Zambia, who migrated to work in mines and farms (Mabvurira *et al.*, 2012).



### *iii) Overstretched Alternative Care Institutions*

Child-headed households in sub-Saharan Africa have also emerged as a result of insufficient and unsuitable institutional care options (Phillips, 2011). The mandate of alternative care facilities such as foster and children's homes is to take in children who have no safe care options. However, as Phillips points out that these facilities are often too full to take in more children; leaving them to form child-headed households.

The detrimental effects of institutional care on children's wellbeing are well acknowledged. Over the years, global policies have discouraged the placement of children in institutional care, using it only as a last resort (Whetton *et al.*, 2009; Heyman *et al.*, 2007). Institutions are not culturally appropriate (Beard, 2005) and deprive children of a family environment. Arising from the huge discrepancy between caregivers and children – few caregivers and many children – children may fail to have an individual relationship where they connect and emotionally bond with an adult, which affects their psychological development.

However, Whetton *et al.*'s (2009) comparative study of the wellbeing of children living in institutions and in community-based care settings, showed the former to have higher intellectual functioning and memory, and lower social and emotional difficulties. In addition, institutionalised children had higher health scores than community-living children. The authors argue therefore that institutional care should not be branded as damaging and inappropriate for all children. Findings from another study in five low-income countries further corroborate this, showing that children in family-based care are at a higher risk of sexual and physical abuse than those in institutional care (Gray *et al.*, 2015).

Braitstein (2015) stresses that it depends on the specific circumstances as to whether institutional or extended family care is best for orphans. Braitstein points out that given the widespread poverty and high dependency ratio in extended families in sub-Saharan Africa, institutions may not be a bad option.

iv) *Children Prefer Living Alone*

Child-headed households are also formed out of children's own preference, and do not always indicate the extended family's failure to absorb them (Foster *et al.*, 1997). Some orphans prefer to live alone for a number of reasons and form child-headed households as a coping strategy. Francis-Chizororo (2008: 260) describes this as "a historical strategy of resistance to unbearable situations". These unbearable situations range from exploitation and abuse by relatives, to loss of property and inheritance.

Numerous studies (Foster, 2004; African Child Policy Forum, 2010) report that orphans are taken in by relatives for their economic value and are normally used as domestic servants. This is evident in Young and Ansell's study (2003) in Lesotho where children living with relatives reported being incorporated into households as workers. Some relatives do not want these orphans but feel, as is culturally expected, compelled to take in the deceased relative's children and end up exploiting and abusing them. In most cases men/uncles impose the decision to care for these orphans without consulting their wives, and as a result children receive hostile treatment from aunts. Children fear this exploitation; they are indeed aware and afraid of the possibility of neglect, abuse and exploitation. In Dalan's study (2009), children indicated fear of becoming house servants in the extended family as a reason for not moving in with relatives. Similarly, in Francis-Chizororo's study (2009), children indicated that they were well aware of the challenges of staying with relatives, even though they had not experienced it first-hand. Children indicated that ill-treatment while living with relatives was the main reason for establishing their own child-headed households; they described their living conditions to be equivalent to that of a prisoner or a slave as they were overworked while the relative's children played.

Orphans also feared resentment from children in the foster household, as they would be competing for attention and resources (Francis-Chizororo, 2009). This suggests that orphans are aware of the challenges even before they are orphaned which may contribute towards their decision to remain as child-headed households.

Children also choose to remain in their parents' houses, after they have passed on, in order to safeguard their inheritance. The African Child Policy Forum (2010) contends that orphans'



property is susceptible to usurpation by relatives. This is particularly the case in poor settings, with no legal property wills, leaving children vulnerable to undesirable cultural practices and opportunistic relatives; as a result of the lack of mental maturity and physical strength to resist, children often lose their property. In most African cultures, when a person passes away, their property and belongings are distributed to relatives in remembrance of the deceased. However, if the household does not dissolve, the remaining family inherits this property. Children can, in most cases, keep their property safe by remaining as a household. In Francis-Chizororo's study (2009), orphans reported choosing to stay alone for fear of losing their property, land and inheritance. Similarly, in Luzze and Ssedyabule's Ugandan study (2004), one third of child-headed households were formed in order to safeguard family property.

Alpaslan and Nziyane's study (2011) also found that some of the children were reluctant to leave their homes as their houses were in a better condition than those of their relatives. Poor housing structures and inadequate living space is therefore also a deterrent to preventing orphans from moving in with their relatives, leaving them to form child-headed households.

Child-headed households also emerge as a result of children not wanting to separate from their siblings, which is likely to happen when absorbed by the extended family. Some children choose to stay together, refusing to leave their homes, rather than being separated or split from their siblings. In some cases, children do not want to separate, because of promises, made to their deceased parents to look after each other. This is very crucial in the Shona culture(s), where it is considered disrespectful and profane to disobey a dying person's wish (Francis-Chizororo, 2009). Furthermore, children often prefer to stay together in their family home, even after the parents have passed away, thereby maintaining the familiar surroundings and "normal" life of the same school, neighbourhood and friends.

The African Child Policy Forum (2008) asserts that children's decision of whether to stay in a child-headed household or move in with relatives is also influenced by the setting – whether the child-headed household is in an urban or rural area. Orphans in rural settings are more likely to choose to remain a child-headed household, as they have a better chance of survival. In rural settings the cost of food, accommodation and education is much lower, with more stable community structures, unlike urban areas where the cost of living is much higher. Rural communities have more closely-knit family and community structures, and are more likely to

absorb children long before the ill parents pass on; in many cases, children might already be living with grandmothers and aunts when parents pass away.

Although children need support and protection, it is important to realise that these children “rationally and consciously” establish child-headed households (Bequele, 2007). A study by Francis-Chizororo (2009) on orphans in child-headed households in rural Zimbabwe examined how the escalating HIV epidemic has reconstructed the notion of childhood, through exploring the formation of child-headed household and coping strategies. In her study, Francis-Chizororo argues that there is the danger of assuming that children are not survivors, yet they should be viewed as agents and decision makers, who can consciously choose to live in child-headed households. Similarly, Luzze and Ssedyabule (2004) argue that these households should be recognised as independent households.

Child-headed households are becoming a reality and permanent feature of society and are increasingly viewed as a new coping mechanism for the overburdened traditional safety nets and insufficient alternative care options (Kurebwa and Kurebwa, 2014; Phillips, 2011; Chirwa, 2002). In South Africa and Namibia, child-headed households are recognised as a form of alternative care arrangement (Cantwell and Holzscheiter, 2008). The UN Committee on the Rights of the Child (CRC), in their Concluding Observation on Ethiopia in 2006, acknowledges the phenomenon of child-headed households and explicitly recommends assistance for them (author? 2006: 8).

### **3.3.3 Experiences of Orphans in Child-headed Households**

In addition to being an orphan, children living in child-headed households experience multiple deprivations. A growing body of literature has shown that they experience extreme income poverty, insufficient food, clothing, shelter, psychological distress, school drop-out, poor housing and sanitation and no access to health care services (Cluver and Gardner, 2007; Ward and Eyber, 2009; Makame *et al.*, 2002; Delva *et al.*, 2009; Dalen, 2009; Mahati *et al.*, 2006; Chingono *et al.*, 2006). Children’s wellbeing is often dependent on an adult caregiver, who is able to support them financially, materially and emotionally. Although some scholars argue that all children living in impoverished households are the same, regardless of who is heading the household (Richter and Desmond, 2008), this thesis argues otherwise, as an adult guardian not only

provides material support but emotional support and physical protection to children. In addition, although impoverished, in an adult-headed household, children do not carry the burden of heading a household. On a psychological level, children living in child-headed households may have experienced multiple bereavements, rejection by relatives, stigma and inheritance battles and are likely to experience greater psychological distress than children in impoverished adult-headed households. Donald and Clacherty's study (2005) supports this, as they compared the wellbeing of children living in child-headed households with those living in adult-headed households and found the former to be more vulnerable. The mere absence of this adult caregiver in child-headed households can therefore compromise children's wellbeing and consequently reduce their quality of life. A discussion of these experiences is presented in this section.

*i) Parentification*

As discussed earlier, most child-headed households are established during parental illness (Maqoko and Dreyer, 2007). Some children become caregivers, nursing ill parents, and it is at this stage that children take up responsibilities of caregiving to siblings, disciplining, household chores, decision-making, and income generating roles (Evans, 2010). These responsibilities continue in child-headed households after parents pass away. In Mkhize's (2006) KwaZulu-Natal study, child heads assumed adult roles, including decision-making, housekeeping, care-giving, economic provision and conflict management. These roles are normally taken by an adult guardian in adult-headed households. This assumption of parental responsibilities is referred to as "parentification" (Moffett, 2007). By definition, parentification is "the familial interaction pattern in which children and adolescents are assigned roles and responsibilities normally in the province of adults in a given culture" (Mika *et al.*, 1987 in Moffett, 2007: 15). Parentification is a challenge specific to orphans living in child-headed households, compared to orphans living in adult-headed households.

The assumption of household head may be defined by gender, age or agency and is highly influenced by cultural norms. The oldest child may assume the role of household head, as is evident in Evans' study (2010), where age was the determining factor for headship in youth-headed households. In addition, the oldest girl may take on the "motherly" role or the oldest boy may assume a "fatherly" role, depending on cultural and household dynamics. Evans (2010)

suggests that these two variables of age and gender of the household head influence the success of the child-headed household. Furthermore, the most resourceful child, in terms of ensuring household survival, may become the household head (Francis-Chizororo, 2010; Evans, 2010). In some cases, headship is highly contested and continuously negotiated. This is evident in Francis-Chizororo's study (2010), where there were no fixed boundaries to being a household head.

Jurkovic *et al.*, (1999) developed a typology of roles in defining appropriateness of responsibilities a child assumes, which includes four types of roles: infantilisation, healthy non-parentification, adaptive parentification and destructive parentification. In the "infantilisation" role, a child does not assume any responsibilities and is dependent on its parents (Moffett, 2007). In healthy non-parentification, children are assigned age-appropriate tasks such as washing dishes and no rigid roles are placed upon them at this stage. Adaptive parentification occurs when a child is unexpectedly thrust into an adult role during a crisis, and is often short term, such as when a parent falls ill. Destructive parentification occurs when a child receives excessive responsibility which impinges on the child's development (Moffett, 2007). This is the type of parentification that occurs in child-headed households, as a child becomes responsible for the financial, food security, health, physical safety and material wellbeing of the entire household.

Research has shown that the assumption of these roles, has detrimental effects on children as their education, childhood, psychological wellbeing and physical health are all negatively affected. One of the most significant changes that come with parentification is the loss of childhood, as children are forced to become adults and perform parental responsibilities. Francis-Chizororo's study (2008) reveals the changing nature of childhood in Zimbabwe; as the epidemic deepens, children are assuming adult roles. In Awino's study (2010), one child reported that she felt that spending time with her peers was a waste of time and she would rather spend time with older women who could guide and support her in heading her household. This indicates the changing needs and priorities of children as they assume parental roles.

Children are deprived of opportunities for play, leisure and recreational activities as well as friendships. In one study in South Africa, child heads reported having limited time to play with friends owing to the increased workload, and yearned for support from adults (Masondo, 2006). Similar findings were found in van Breda's (2010) study. Studies have shown that children in child-headed households share responsibilities, as tasks are split across all household members

reducing the burden on household heads (Korevaar, 2009; Evans, 2010). In Francis-Chizororo's study (2010), chores were distributed amongst household members, with every member contributing towards income generation and food production. However some responsibilities still remained with the head, such as decision making and management of finances.

Children's education is often interrupted, as children leave school to assume this parental role (Masondo, 2006). In a study in Uganda, youth-headed households failed to complete their primary and secondary education as they assumed breadwinning roles (Evans, 2010). The psychological distress of assuming this parental role also affects children's school performance.

Adult role-taking has been associated with internalised emotional distress (Moffett, 2007; Geldenhuys, 2016). Phillips (2011) points out that child heads are physically and mentally immature and not adequately equipped. This is not always, however, the case, as numerous studies have shown child heads to be capable and resourceful individuals (Francis-Chizororo, 2008). In addition to household and livelihood tasks, the child head provides emotional support to his/her siblings. Child heads often carry the emotional stresses of the household as they struggle with food insecurity and earning income as an adult parent would. Jurkovic *et al.*, (1991) refer to this as "expressive parentification". As "parentified" children struggle to meet their siblings' material and emotional needs, their own needs for love, care and support remain unmet (Evans, 2010). In a study in Tanzania and Uganda, older siblings internalised their feelings, as they did not want to share them with their younger siblings for fear of causing further distress. Youths therefore sacrificed their emotional wellbeing in an effort to protect their siblings (*ibid*).

It is however, important to understand parentification within the cultural context in which it occurs. Studies have shown that in many African cultures, older children look after their younger siblings (Evans, 2010; Francis-Chizororo, 2008). Evans (2010) points out, that "sibling caretaking" is a common childcare strategy that enables mothers to engage in food and income production. Francis-Chizororo (2010) also points out that in the Shona culture in Zimbabwe, the notion of children assuming parental roles and socialising other children is not entirely new. This may be the case in many African cultures where older children assume some adult and parental responsibilities as a mechanism for socialisation and spreading families' responsibilities. Similarly, Moffett (2007) cautions that childhood, is a socio-cultural phenomenon that is

conceptualised differently in terms of responsibilities, rights and needs. Children in most parts of sub-Saharan Africa are assigned some household chores such as cooking and cleaning, and are trained at an early age in basic life skills. So, for many children in child-headed households, these responsibilities are not all entirely new to them. What may be new and challenging is carrying the emotional stress of looking after the household. Scholars also argue that assuming parental roles has psychological and resilience enhancing benefits for children (Chase, 1999 in Moffett, 2007). Cluver (2007) also points out, that household chores, when undertaken in moderation, are beneficial for children.

The process of parentification in child-headed households brings out/creates dynamics of hierarchy and power relations as well as gender and cultural division of labour. Division of labour and assumption of headship may be influenced by culture and context as most cultures have gender and culturally defined roles. In Francis-Chizororo's study (2010), parental responsibilities were assumed along gender lines, with girls performing "motherly" responsibilities such as cooking and cleaning while boys performed "fatherly" responsibilities of income generation. Although headship may be contested, a hierarchy exists with one [or more] child assuming this role; thus like adult-headed households, child-headed households also consist of structured hierarchies amongst members.

## *ii) Poverty*

Children in child-headed households often live in extreme poverty (Phillips, 2011), which is indisputably one of the most significant challenges experienced by these orphans (MacLellan, 2010). Numerous studies attest to this. In these households, poverty often translates into a myriad challenges such as lack of food, dropping out of school, poor housing and possibly homelessness; it can therefore be considered a catalyst for the challenges experienced in child-headed households.

As indicated above, children's financial and material deprivation begins well before child-headed households are formed. Funds are often depleted during the prolonged illness of parents, as savings are used up and assets are sold to meet the cost of medication and household upkeep (Phillips, 2011). Also, after parents have passed away, remaining assets may be taken by



relatives. Consequently, orphans often begin their lives in child-headed households with very limited resources. This could lead children into chronic poverty.

Several studies have shown that child-headed households often experience extreme poverty and financial insecurity (Donald and Clacherty, 2005; Meintjes *et al.*, 2010; Ward and Eyber, 2009; Masondo, 2006; Awino, 2010; Nkomo, 2006; MacLellan, 2010; Korevaar, 2009). Meintjes *et al.*'s study (2010) indicates that children in child-headed households experienced greater income poverty and had less access to services compared to children in adult headed households. This is also evident in Donald and Clacherty's study (2005), where child-headed households survived on one third of the resources compared to those of similar adult headed households. A survey in South Africa, matched household sizes to the household's total monthly income, and 44.3% child-headed households were found to be living in absolute poverty (Chiastolite, 2008).

To generate household income, children engage in various activities ranging from contract labour on farms to hawking and begging (Kurebwa and Kurebwa, 2014; Germann, 2005a; Chase *et al.*, 2006). This may affect children's education as some may drop out to engage in these livelihood activities. The International Labour Organization (ILO) recognises children's engagement in work when it does not affect their health, personal development and schooling (2012), and differentiates this type of work from child labour, dependent on the child's age, type of work, hours and conditions. The ILO Convention on the Minimum Age for Admission to Employment (Convention 138) stipulates that the minimum age for basic work is 15 years and for light work its 13 years (ILO, 1973), while the Convention on the Worst Forms of Child Labour (Convention 182) prohibits children below the age of 18 years from engaging in hazardous work. The worst forms of child labour include prostitution, forced and illegal military service and dangerous industrial and agricultural work (Bequele, 2007).

These children however have limited prospects, as they lack the essential skills and resources required in the labour market. As a result, children are at a higher risk of being siphoned into exploitative labour, prostitution and criminal acts (Phillips, 2011; Ward and Eyber, 2009; Bequele, 2007; Foster, 2004). Children may be exploited through receiving low wages, working long hours, working in hazardous conditions and being sexually exploited. There is increasing evidence that girls heading households, are sexually abused and engage in transactional sex

(MacLellan, 2010). This creates what Masanjala (2006) terms the poverty-HIV nexus, whereby poverty increases girls' vulnerability to HIV infection.

This lack of skills and limited livelihood opportunities magnifies the material deprivation in child-headed households (Walker, 2002). In Ward and Eyber's study (2009), economic insecurity was distressing for older children who assumed breadwinning roles; when income generating efforts were unsuccessful, children were left feeling powerless, discouraged and anxious. Consequently, children's food security, education, utilisation of health services, housing and living conditions are compromised. Luzze (2002) lists these four conditions as core needs for children in child-headed households. These are individually discussed in this chapter. Thus, these aspects of well-being become dependent variables of economic resources. This relationship between income and wellbeing is supported by Stein's (2003) assertion that the social and economic dynamics of poverty, appear to be the root causes of children's vulnerability rather than HIV/AIDS. Bray (2003 *in* Snider and Dawes, 2006: 20) contends that "poverty is the principle vehicle through which AIDS works to further disadvantage children". Although engaging in livelihood activities provides solutions to the immediate short term challenges of income and food insecurity, it has long term implications. Children drop out of school, are deprived of their childhood, and compromise their physical health. By losing their education, children miss the opportunity to break out of poverty. Thus, "child labour is both a cause and consequence of poverty" (Nicholson, 2008: 425) as it condemns children to pervasive poverty, a life without dignity and is a denial of children's rights.

Nicholson (2008) suggests implementing government funded social welfare safety nets that address economic and food security in child-headed households. However, given Zimbabwe's limited resources, dire economic stagnation, political turmoil, bureaucracy and corruption, social protection has not been very successful. Furthermore, although many countries have social protection grants to buffer vulnerable populations, children in child-headed households are often excluded as they are minors and ineligible to apply without an adult guardian (Phillips, 2011). In cases where children are eligible to apply on their own, application procedures are complicated, time-consuming and require documents that children often do not have. Furthermore, children are often unaware of these grants and other social welfare services available to them. Phillips (2011) points out that in such cases, individuals and organisations take advantage of these child-



headed households, and apply for grants on their behalf, but in the end the grants do not benefit or reach these households. In some cases, children in child-headed households lack the necessary legal documents such as birth certificates and parents' death certificates resulting in their not receiving their rightful grants and other social support (Human and Van Rensburg, 2011).

The socio-economic forces in the environment contribute to social suffering for these youths (Lee, 2012). Lee (2012) applies Vigh's (2008) concept of *settings of chronic crisis*. The concept reflects on people's normalisation and routinisation of crises. "Social navigation" describes how these people steer their lives through this environment (Christiansen *et al.*, 2006 in Lee, 2012).

Most of these studies however, fail to take into consideration the role of structural level deficiencies, such as policies and institutions that may contribute to individual suffering or inhibit children's ability to cope. There is need for further research on the impact of structural influences on the wellbeing of child-headed households.

### *iii) Poor Health Outcomes*

In addition to the factors influencing health outcomes discussed earlier, orphans living in child-headed houses have their health affected by being unable to afford buying adequate and nutritious food, non-utilisation of healthcare services, poor living conditions, hazardous livelihoods and low health literacy.

In the absence of an economically active adult, many orphans in child-headed households live in dire poverty, which is a significant determinant of health, as it influences their living conditions, food choices and their access to clean water and adequate sanitation. With limited income in child-headed households, the financial means to buy adequate and healthy food dwindles. These households therefore experience food insecurity. Food insecurity is the state when people do not have physical, social and economic access to sufficient and nutritious food to meet their dietary needs and food preferences for an active and healthy life (The Food and Agricultural Organization of the United Nations, 2003). Research has shown that food insecurity is the most common and critical challenge in child-headed households (Masondo, 2006; Ibebuike *et al.*,

2014; Nelson Mandela Children's Foundation, 2001; Tsegaye, 2008). As a coping strategy children reduce meal quantities and meal frequency (Chase *et al.*, 2006).

In a situation analysis of child-headed households in Swaziland, the average diet in child-headed households consisted largely of carbohydrates and lacked essential nutrients such as protein and fat (UNICEF, 2009). Thus, children in child-headed households are at a greater risk of malnutrition and are likely to experience challenges such as iron deficiency, anaemia, impaired vision and growth retardation (Gubwe *et al.*, 2015). Furthermore, malnutrition affects children's cognitive and mental development and as a result they experience difficulty in concentration and performance at school. Several studies have shown that malnourished children are likely to start school later and drop out compared to healthier children (Alderman, Hoddinott and Kinsey, 2003; Behrman, 2000; Behrman *et al.*, 2003; Glewwe, Jacoby and King, 2001; Grantham-McGregor *et al.*, 2007). In contrast however, Donald and Clacherty's (2005) study found no significant differences in Body Mass Index between children living in child-headed households and those in adult-headed households.

Children in child-headed households also experience poor health arising from failure to seek medical treatment when necessary. Children do not utilise healthcare services owing to fear of stigma, lack of time and unaffordability of healthcare services. As discussed earlier, most child-headed households are affected by HIV/AIDS in one way or another; their parents may have died of HIV related illnesses or they may be HIV infected themselves. As a result, these children may experience stigma and discrimination from neighbours, relatives and friends (Dalen, 2009; Gubwe *et al.*, 2015). This prevents children from accessing healthcare services within their communities as they fear being seen at health facilities, risking further stigma and discrimination (Shabalala, 2013). Stigma and discrimination are well acknowledged barriers to the utilisation of healthcare services (Ross and Deverell, 2004 in Korevaar, 2009). In Korevaar's study (2009), a local NGO transported children from child-headed households to clinics outside their communities to prevent them from being stigmatised.

Hostile attitudes of health care workers towards unaccompanied children, also prevents them from utilising health care services. In many cases children are turned away and asked to bring an adult guardian (Sibanda, 2015; Shabalala, 2013). Access to health and other social services can be challenging, without both an adult guardian and legal identity documents such as birth

certificates (Maqoko and Dreyer, 2007; Mahati *et al.*, 2006). A study by Luzze and Ssedyaabule (2004) in Uganda found that orphans living in child-headed households had less access to social services than other orphans. The lack of an adult guardian is a confounding factor as after being turned back they have no guardian to take them.

In addition, arising from the burden of caregiving and income-generation, many children do not have time to go to health care facilities, which may entail travelling long distances, transport costs and queueing for hours (Sibanda, 2015). Sibanda found that these three factors, long distances to the health care facility, unreliable transport system and long waiting hours, significant barriers to utilising health care services amongst children living in child-headed households in rural Swaziland. In addition, their lack of money and ignorance contributed towards low utilisation of health care services in these households. This failure to utilise healthcare services when necessary, results in poor health, lowered immune systems and continuous vulnerability to illness (MacLellan, 2010).

Furthermore, child-headed households often live in appalling conditions, which could have negative effects on their health. Many child-headed households live in dilapidated houses with no running water and sanitation, as they cannot afford rentals. The Commission on Social Determinants of Health (2007) notes that the structure of dwellings and internal conditions such as damp, cold and indoor contamination have direct impact on an individual's health.

In an effort to earn income, many children from child-headed households engage in various livelihood activities, many of which are dangerous, exploitative and detrimental to their health. For example, many young girls engage in commercial sex work, which exposes them to physical violence and sexually transmitted infections including HIV.

A household consisting only of children, often with limited education and knowledge, is likely to have a limited level of health literacy, which is “the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health” (South Australia Council of Social Services, 2008: 10). In many cases, these children are not able to make informed health promoting decisions. Such decisions may include, for example, boiling untreated water before consumption.

Furthermore, the absence of an adult in unaccompanied child-headed households may affect children's health seeking behaviour (Amuge *et al.*, 2004). Children require guidance in making decisions and lifestyle choices such as healthy eating, wearing warm clothes in cold weather, taking care of one's body, monitoring adherence for children on medication and other health promoting actions. In addition, the absence of such support influences children's behaviour as they grow up. Without this guidance, children may engage in behaviours that are detrimental to their health such as smoking, alcohol and drug consumption (Konopleva and Larin, 2013). From the discussion above, it is evident that the multiple deprivations and complex dynamics of child-headed households, compromise the health of children living in them.

#### *iv) Poor Housing and Living Conditions*

Because of their lack of property rights and limited financial resources, many child-headed households live in deplorable conditions with no access to clean water, adequate sanitation, and electricity (Amuge *et al.*, 2004; Phillips, 2011). Orphans often struggle to obtain property rights over their deceased parents' property, as they are minors and cannot legally sign off on property deeds (Phillips, 2011). In addition, orphans risk having their rightful inheritance taken away by relatives (MacLellan, 2010).

Children from child-headed households are also unable to afford purchasing or renting proper houses. As a result, many child-headed households live in sub-standard structures such as poorly built brick houses, shacks, temporary shelters and makeshift tents (UNICEF, 2003; Luzze, 2002). In a study in Mozambique, child-headed households lacked safe and adequate housing, living in thatch and mud houses which they struggled to maintain during rain storms (Roby and Cochran, 2007). Child-headed households in Rakai district, Uganda were also found to be living in appalling conditions with collapsed walls and leaking roofs (Dalen *et al.*, 2009: 2, 5). These houses are often located in poor under-serviced areas. In a study by Coetzee and Streak (2004: 18), 90% of child-headed households had no proper toilet facilities and used pit latrines; only 66% had electricity and the majority did not have a water supply in their homes and relied on communal taps.

Some child-headed households are homeless and live on the streets, sleeping under bridges or in other sheltered areas. In the Mozambique study, some child-headed households did not have physical structures and slept outside in the open (Roby and Cochran, 2007). This makes children extremely vulnerable, as they are exposed not only to harsh weather conditions but are also vulnerable to sexual and physical abuse and to being robbed of their daily earnings. Such living conditions are dangerous and contribute to poor health outcomes for these children, as an individual's living environment is an important risk factor for health and wellbeing (Hood, 2005; Marais *et al.*, 2013; Evans, 2003; Rourke *et al.*, 2012; Dunn *et al.*, 2006; Raphael, 2004; Roby and Cochran, 2007). Research has consistently shown that people living in economically deprived areas, experience poorer health outcomes compared to those in non-deprived areas (Poortinga, 2012).

v) *Education Challenges: Enrolment, Performance and Retention*

As discussed earlier, orphans' education is compromised by poor health, poverty, psychological distress, hunger and inadequate resources. For orphans living in child-headed households, these barriers are magnified as children are the sole caregivers and breadwinners. This conflicts with their educational needs and exacerbates their poverty, psychological distress and food insecurity situation.

The challenge of obtaining money to continue with education is substantial for orphans with no guardians and relatives caring for them. Research has shown that many children living in child-headed households drop out of school while others fail to even enrol because of failure to raise funds for school fees (Makame *et al.*, 2002; Dalen *et al.*, 2009; Delva *et al.*, 2009; Cluver and Gardner, 2007; Awino, 2010; Korevaar, 2009). A study in South Africa showed that orphans living in child-headed households struggled to find money for school fees compared to orphans living in adult-headed households (Donald and Clacherty, 2005). In a study in Kenya, children from child-headed households were excluded from school, owing to their failure to pay school fees and examination fees (Awino, 2010).

The dilemma in child-headed households is that children are both breadwinners and also need to be in school; if they attend school, they are unable to raise funds and if they are to engage in

livelihood activities they are forced to drop out of school. As a coping strategy, the older children, usually the household heads, sacrifice themselves and drop out of school to earn income and raise school fees for their siblings. This was evident in a situation analysis of child-headed households in South Africa, where 87% of children were paying school fees for themselves and the household heads were out of school working to raise school fees for their siblings (UNISA, 2008). Awino's study (2010) highlights how household heads engage in numerous income generating activities in order to raise money to send their siblings to school. Masondo (2006) established that realising the value of education, child heads sacrifice their own education so that their siblings are able to acquire an education. This notion of self-sacrifice is a common coping strategy in child-headed households, not only for school attendance but for food security as well.

However, in Mthethwa's study (2009), she found that all children in child-headed households were enrolled in school. This high enrolment in Mthethwa's study was influenced by the support that schools provided to children, as 60% of the children indicated receiving material support from school. School enrolment amongst child-headed households is also influenced by the availability of social protection programmes such as school fees waivers or bursaries. Oleke *et al.* (2007) also point out that in countries where there is free primary education, school fees are not a barrier for younger children in child-headed households. Free primary education reduces the financial burden in these households, enabling older children in secondary school also to attend school. Furthermore, Mthethwa's findings may also signify children's resilience, as they overcome barriers to education.

Although primary education may be free, there are still hidden costs of uniforms, school material and transport, which may be out of reach for many child-headed households (Phillips, 2011). This is evident in Dalen *et al.*'s study in Uganda, where 61% of children from child-headed households were not in school, largely because of the costs of uniforms and school materials (2009). Similarly, one study in South Africa showed that children from child-headed households dropped out of school as they could not afford stationery and uniforms (Masondo, 2006). *The Global Education Monitoring Report 2015* also shows that in countries where education is free, households still incur large education related costs; thus it is not "free" education in the real sense, and hidden costs not only affect enrolment and retention, but performance as well.

Furthermore, in child-headed households the opportunity cost of school attendance is substantial, as children need to fend for themselves, engaging in food production, income generation and caregiving. Children are thus constantly confronted with the need to choose between performing these tasks and attending school. Each time they choose to attend school, they potentially compromise their household's food and economic security. These livelihood, food production and caregiving responsibilities are onerous and are barriers to school retention and performance in themselves; these are discussed later in this section.

Gubwe *et al.* (2015) discuss the complexities of education, indicating that it goes beyond a child's enrolment. Other complexities that may hinder school attendance and performance include hunger, household responsibilities and children's psychological state. Several studies show that the need to generate income in child-headed households is a significant barrier to school attendance (Nelson Mandela Children's Fund, 2001; UNISA, 2008). In addition to school fees, children need money for food, housing, clothing, toiletries, healthcare and other material needs. Although abolishing school fees massively reduces the cost of education, free primary education on its own is not sufficient for children to realise education; additional strategies are required to ensure retention and performance.

In addition to financial responsibilities, children in child-headed households have caregiving responsibilities that may interfere with their school attendance and performance. In the nature of household composition, children are the caregivers, with older children looking after younger ones. As discussed earlier, children are responsible for cooking, cleaning, agricultural food production and caring for young siblings. These responsibilities are onerous and children often fail to attend school at the same time. For example in a child-headed household with a baby or very young child, the oldest sibling is forced to drop out of school and look after the baby. In one study, participants reported having shifts to look after their baby sister; when one attends school, the other is looking after the baby (Masondo, 2006). This resulted in both siblings, having high rates of absenteeism, as they miss school every other day. A study in Kenya showed that heavy household chores were the main cause of absenteeism amongst children living in child-headed households (Phillips, 2011). Similarly, two studies in South Africa (Masondo, 2006 and UNISA, 2008) also found caregiving responsibilities to be barriers to school attendance. In Pufall *et al.*'s study (2014), young carers were less likely to be attending school compared to other children. In



the same study, orphans were also less likely to be in their correct grade as a result of interruptions to attendance. Several studies confirm this (Ainsworth *et al.*, 2005; Bicego *et al.*, 2003; Kasirye and Hisali, 2010 in Pufall *et al.*, 2014).

The emotional stress of having to head a household, struggling to earn an income and living alone in fear is significant. Child heads carry the household burdens, and often experience anxieties which may hinder their attendance, concentration and participation in school, and may even cause them to become too stressed to attend school (Masondo, 2006; Mkhize, 2006). Furthermore, the stigma, discrimination and isolation that orphans and children living in child-headed households experience, may reduce their self-esteem and confidence to participate in class (Gubwe *et al.*, 2015). Confronted with these challenges, many children living in child-headed households drop out of school.

In addition, many orphans in child-headed households do not have birth certificates and identity documents, and are often not able to register and enrol for school. This is particularly the case for the younger children who reach school going age after their parents have passed away as well as for older children progressing to secondary school and needing to register. In Namibia, pregnancy among children from child-headed households was also a contributing factor to school dropout (Ruiz-Casares, 2007).

The implications of failure to attend school are numerous and far-reaching for child-headed households. Firstly, children miss out on the numerous psycho-social and protective benefits of school. Importantly, children fail to acquire knowledge and skills, diminishing their future income generation capacity as adults (Mogotlane *et al.*, 2008).

The “obvious” long term benefit of attending school is the acquisition of knowledge and skills, since a child who has access to primary and secondary education has a better chance in life. Educational qualifications and skills equip children to improve their access to income and become economically empowered adults. For children, living in poverty, such as those from child-headed households, education provides an opportunity to escape the vicious intergenerational cycle of poverty. In the long-term, children who have attained educational qualifications have the potential to have a better quality of life in adulthood with increased



income, and their households have better access to resources such as housing, water, sanitation, food and healthcare.

Schools have protective and preventative benefits and there is growing recognition of their potential source of support for vulnerable children; they have often been referred to as “nodes of care and support”, “inclusive centres” and “healthy schools” (Khanare, 2012: 251) as they provide the much needed psychosocial support. Schools are protective in that they reduce children’s vulnerability and exposure to violent environments. It is well established that children living in child-headed households are vulnerable; their homes are often not safe, particularly for girls, and they may be exploited or coerced to engage in illegal activities (Korevaar, 2009). By attending school, children therefore spend most of their time at school and less time at home, reducing their vulnerability to exploitation or influence.

Moreover, the school as an institution provides structure and stability for children coming from violent and unstable environments. Social control and social order enforced at school, exposes children to discipline which may otherwise be lacking at home; for example, children learn that all actions have consequences. This is particularly important for children who have acquired deviant behaviour arising from lack of parental and guardian support. Tasmajian (2002) indicates that it is possible for children to unlearn inappropriate behaviours and learn new ways through interaction with peers.

Schools foster children’s personal development, in particular their physical, mental, emotional and social development (Darji, 2010). They provide a platform for children to socialise and experience growing up with other children (Makame *et al.*, 2002), and offer an important buffer for orphans through social cohesion and the friendships they make at school (Skovdal and Ogutu, 2012). Peer interaction and socialising with friends is viewed as a protective factor, as it gives comfort to children and takes their mind off problems at home, building their resilience (Cluver, Bowes and Gardner, 2010; Wild, Flisher and Robertson, 2011). For children in child-headed households, time spent with friends offers a break from routine care and household chores (Campbell *et al.*, 2010). In Skovdal and Ogutu’s study (2012), friendships served as more than emotional support: friends shared materials such as school materials and food, and helped each other with household chores and income generating activities. Similarly, in a study by Campbell, Skovdal, Mupambireyi and Gregson (2010), friends also helped with household chores. The

challenge however, is that when children drop out of school, they struggle to retain these friendships. Dropping out of school could therefore result in social poverty, as evidenced in several studies (Skovdal and Ogutu, 2012; Dalen, Nakitende and Musisi, 2009; Yanagisawa, Poudel and Jimba, 2010).

In addition, the various activities that children engage in at school, such as sports, extra-curricular activities, arts and field trips all contribute towards their development as healthy balanced social beings, allowing children to develop cognitive and problem-solving skills.

Education is often referred to as the “social vaccine against HIV” because it equips children with the knowledge, attitudes and beliefs to grow up free from HIV (USAID and Catholic Relief Services, 2008). UNICEF and UNAIDS Unite for Children, Unite Against AIDS Campaign recognises education as a crucial weapon in preventing HIV infection amongst children and adolescents who thereby acquire knowledge on how to protect their bodies and prevent pregnancies, STIs and HIV. A study in Kenya (Cho *et al.*, 2011) showed that keeping orphan girls in school was associated with delayed sexual debut. Similar findings from Zimbabwe (Hallfors *et al.*, 2011) indicated that school attendance increased orphan girls’ concerns about the consequences of sex. The authors conclude therefore that school attendance is protective against HIV risk amongst orphan girls.

#### *vi) Psychological distress*

Although all orphans experience some form of psychological distress, research suggests that as a result of the combination of multiple deprivations, numerous responsibilities and the lack of adequate social support, orphans living in child-headed households are more vulnerable to psychological distress (Cluver *et al.*, 2007; Korevaar, 2009). Masondo (2006) concurs and indicates that children from child-headed households often experience feelings of helplessness, hopelessness, vulnerability, loneliness, emptiness, a desire for a fulfilling life and fear of the unknown. This is illustrated in Atwine *et al.*’s (2005) study in Uganda, where orphans in child-headed households experienced higher levels of anxiety and symptoms of depression. Korevaar (2009) indicates that orphans in child-headed households are likely to experience cumulative stress as a result of lack of adequate care, poor nutrition, illness, economic deprivation, disrupted

schooling, uncertainty, stigma and social isolation. Additional factors influencing psychological distress include new responsibilities and fear of living alone.

Children continue to experience this grief as they establish their child-headed households. Korevaar (2009) also points out that the changes in living arrangements after parents have passed away also exacerbate children's psychological distress. Children may be moved several times between relatives before eventually establishing child-headed households, creating a feeling of displacement and instability.

Heading a household in particular, is a stressful role which children are seldom emotionally prepared for and seldom capable of coping with. The experience of heading a household may therefore be overwhelming for children. This could lead to psychological distress characterised by depression, suicidal ideation and behavioural difficulties (Harms *et al.*, 2010; Cluver *et al.*, 2007; Cluver and Gardner, 2007a; Atwine *et al.*, 2005; Makame *et al.*, 2002). In a study in Uganda, children who performed household chores, frequently had higher anger scores (Awine *et al.*, 2005). This illustrates the psychological effect household responsibilities may have on children. In addition, child heads often experience feelings of abandonment, fear and insecurity as relatives and community members fail to support them. According to the Nelson Mandela Children's Fund (2001), heads of child-headed households experience higher levels of psychological and emotional strain. Similarly, Moffett (2007) notes that orphans suffer from stress resulting from adapting to adult roles, with minimal resources available.

However, other studies have shown children living child-headed households to be psychologically resilient as they adapt to their new roles and living conditions. Francis-Chizororo (2008), cautions against the assumption that children are vulnerable and incompetent victims, incapable of helping themselves.

Social isolation and the lack of parental affection, affects children's psychological wellbeing. Literature shows that many child-headed households are socially isolated with limited and weak social networks (Awino, 2010; Nkomo, 2006). This lack of support exacerbates orphans' grief process after parental death. In addition, disputes over property inheritance and the adoption and separation of siblings by relatives, cause tremendous psychological distress to children (Nyamukapa *et al.*, 2010; Gong *et al.*, 2009). Many child-headed households are unaccompanied,

with no adult support, and thus children lack caregiver attachment. This is a crucial developmental stage, particularly for younger children. The bond between a parent and child, provides relationship skills and is the foundation for other relationships that a child forms later in life (Phillips, 2011).

The lack of support from the extended family is often associated with feelings of rejection and not being loved (Cluver and Gardner, 2007a). This is evident in van Breda's (2010) study of child-headed households in South Africa, where children reported experiencing feelings of deprivation and abandonment by relatives, whom (they feel) should have been looking after them. These feelings often lead to unhappiness and depression, compromising children's satisfaction with life. Orphans also experience grief and anger (Nkomo, 2006), possibly the anger of being left alone with such burdens. The effects of social support on children's quality of life, is discussed in detail in the section to follow.

Children living in child-headed households also live in constant fear of their safety: living alone without adult supervision, they are vulnerable to all kinds of abuse (physical, sexual and economic exploitation) (Bequele, 2007). This is a common feeling in child-headed households as evidenced in a study in Zimbabwe, where children feared losing their property, living in poverty for the rest of their lives and the unknown future (Walker, 2002). Also, soon after formation of child-headed households, the fear of separation constantly affects children. Fear relates directly to children's vulnerability. Experiences of various forms of vulnerability and fear, leave scars on children that affect their psychological wellbeing (Foster and Williamson, 2000; Makame *et al.*, 2002).

#### *vii) Social Isolation*

Social isolation heightens children's vulnerability to abuse, exploitation and psychological instability (Thurman *et al.*, 2008). There is increasing evidence that children living in child-headed households experience social isolation as a result of limited social capital and social networks (Masondo, 2006; Awino, 2010; Nkomo, 2006; Thurman *et al.*, 2008). To clearly comprehend the paucity of social capital, social networks and social support in child-headed households, it is important to unpack these concepts.

### *viii) Social Capital*

Social capital is a contested concept (Szreter and Woolcock, 2004). One school of thought conceptualises social capital as social networks. This perspective is shared by Putnam (2007: 137) who defines social capital as “social networks and the associated norms of reciprocity and trustworthiness”. Another school views social capital as both the resources and the networks through which these resources flow (Kim *et al.*, 2006). In this school belong Bourdieu, Coleman and Lin. Bourdieu (1986) views social capital as the actual or potential resources linked to the network (Ferlander, 2007); Lin (1999) defines it as the resources embedded in the social networks and not the social networks themselves. Similarly, Coleman (1988) views social capital as the resources that are by-products of social networks.

In reference to orphans, social capital can be considered as the social resources that children have and make use of, in order to access social support; these include social networks such as neighbours, community members, religious leaders, teachers and their friends. Skovdal and Ogutu (2012: 242) use the term social capital to refer to “the social psychological resources that children invest in and actively negotiate access to in dealing with circumstances”. Social capital is pivotal in the psychosocial wellbeing of all orphans and vulnerable children and particularly crucial for children living in child-headed households.

Recent literature distinguishes between three types of social capital: *bonding*, *bridging* and *linking* (Putnam, 2000). *Bonding social capital* comprises of relationships between people who are similar in terms of their shared social identity (Szreter and Woolcock, 2004). For children living in child-headed households, children may develop supportive and close relationships with other children in child-headed households, built on reciprocity and a shared identity (Skovdal and Ogutu, 2012). This type of social capital can improve health outcomes through transfer of health information, motivation for behavioural change, promotion of access to services and through the provision of psychosocial/emotional support (Kim *et al.*, 2006).

*Bridging social capital* consists of relations of respect and mutuality between people who are not alike (Szreter and Woolcock, 2004). This is when children from child-headed households interact with other children from their community and school, who are not necessarily child-headed

households. *Linking social capital* relates to the networks relationships between people across formal, institutionalised and explicit vertical social strata (Szreter and Woolcock, 2004). In this instance, children relate to people outside their strata, such as teachers and social workers. Although this type of social capital has the weakest relationship, it has valuable outcomes, labelled as the most valuable by Hawkins and Maurer (2010). This is evident in Lee's study (2012), where social capital had an empowering effect, enabling youths to gain control over their lives with economic and emotional support.

The importance of social capital in health and wellbeing is well established (Szreter and Woolcock, 2004; Putnam, 2000). Research has shown social capital to improve child development, improve adolescent wellbeing, and increase mental health (Kawachi, 1999), reduce mortality and reduce psychological distress, such as depression and loneliness as well as higher perceptions of wellbeing and self-rated health (Kawachi *et al.*, 1999; Szreter and Woolcock, 2004; Cohen and Wills, 1985). Furthermore, Coleman (1988) stresses that social capital is an important resource for individuals that may affect their ability to act, and their perceived quality of life. It can act as a buffer to economic deprivation and financial security (Putnam, 2000).

#### *ix) Social Networks*

Social networks and social support play a crucial role in shaping an individual's quality of life. Mitchell (1969: 119) defines a social network as "a specific set of linkages among a defined set of persons, with the additional property that the characteristics of these linkages as a whole may be used to interpret the social behaviour of the person involved". Essentially, social networks are the practical, emotional and instrumental ties that link individuals and groups, whereas social support is the content of these ties (Lee, 2012). For children in child-headed households, these networks are critical and can contribute towards children's physical, psychological and financial wellbeing. These networks include the extended family, neighbours, community members and peers. Social networks are viewed as the core component of social capital and can be categorised as formal, informal, vertical and horizontal ties (Ferlander, 2007).

Bourdieu (1986) stresses that establishing these social networks requires effort and time: this is where children's agency comes into play - their ability to establish these networks and engage



with people at bonding, bridging and linking levels. Children from a child-headed household may have to make an effort to establish ties or a relationship with their neighbours, in order to receive support in the form of, for example, homework supervision. Bourdieu (1986) points out, that social ties are most effective when they result in access to people with more resources and information. Bourdieu however, fails to acknowledge the psychological benefits of social networks. A study in South Africa by Ward and Eyber (2009) reveals the role of social networks in the wellbeing of orphans living in child-headed households. These children's social networks included the extended family and community members; they relied on neighbours and their pastor for advice, and others indicated that they could turn to their grandmothers and uncles with a problem (*ibid*). Children also received emotional support from other children living in child-headed households. Ward and Eyber (2009) indicate that these peer and community networks acted as protective factors that enhanced the children's psychosocial wellbeing. This concurs with literature that notes that contact with immediate and extended family can be a protective factor for children (Cluver and Gardner, 2007). These findings are similar to those of Evans' study (2012), where children's strong formal and informal support networks in rural and urban areas, were crucial for households.

Daniel (2013) discusses support networks available to HIV positive children in Tanzania, and refers to creative kin, which is "a form of 'fictive kin' which describes relationships among people who are unrelated by blood or marriage but look upon each other in kinship terms". This a new type support network and can be considered in cases where there is insufficient support for children.

However, as a result of urbanisation and migration, social networks available to many child-headed households are limited as extended family relationships weaken when family members are dispersed. Furthermore, unlike rural organic communities, urban communities are more diverse and less connected and therefore neighbours feel less obligated to support child-headed households. This is in line with Putnam's (2007) Constrict Theory which posits that increased diversity reduces levels of trust and community participation.

Ferlander (2007), cautions that social capital is not always positive and is capable of producing negative consequences. Daniel (2013), concurs, pointing out that children's social networks can also threaten their wellbeing. Children may also experience negative peer interaction such as

bullying, teasing and stigma (Cluver and Gardener, 2007). Children from child-headed households are particularly vulnerable to this victimisation at school, as a result of their material deprivation, poor health and loss of their parents to HIV related illnesses. For example, when children go to school with a torn uniform and with no shoes they may be teased and marginalised. Thus, not all social networks have positive and supportive effects on children.

#### *x) Social Support*

Social networks provide different types and levels of social support (Hellermann, 2007 *in* Ryan *et al.*, 2008). Social support can be divided into emotional, informational and instrumental social support, as well as companionship (Schaefer *et al.*, 1981; Cohen and Wills, 1985). Emotional support encompasses the provision of empathy, trust and caring. Informational support involves the provision of advice and information, essential for child-headed households, as they are often out of touch with formal structures and may have limited linking social capital. Instrumental support entails practical support (Ferlander, 2007), such as food parcels, clothing, assistance with school fees and with household chores. In Evans' study (2012), children within the child-headed household were a form of bonding social capital, providing instrumental support through sharing domestic responsibilities, as well as the interdependent relationships siblings had with one another. Companionship entails spending time with others, which may come from peers, neighbours and relatives.

In an OVC situation analysis in Zimbabwe, local communities provided social support to child-headed households (Chandiwana *et al.*, 2009). Women formed support groups to look after orphans who were staying in their deceased parents' homes, providing counselling and moral guidance. In rural areas, the practice of *zunde ramambo existed*, a long standing traditional safety net system, whereby the chief receives agricultural produce from villagers, which was provided to support child-headed households. However, as a result of socio-economic constraints, this system has failed to be sustainable, as communities are struggling to feed their own families let alone assist orphans. The communities' ability to respond to the orphan crisis has been constrained by Zimbabwe's multiple challenges (RAAAP, 2004 *in* Chandiwana *et al.*, 2009), which are extensively discussed later in this chapter.



Many children in child-headed households, however, lack the crucial social support of relatives and communities and are often forgotten. In many studies (Ward and Eyber, 2009; UNICEF, 2001; Thurman *et al.*, 2006), children from child-headed households were severely isolated with little or no support from the extended family, nor the community. In one particular study (Dalen, 2009: 198), children emphasised that they felt “adults did not understand the reality of their daily life” and could not support them when they were “alone, afraid, uncertain about their future and confused about what had happened to them”. An ethnographic study conducted in Zimbabwe found that child-headed households experienced extreme social isolation with no social networks to turn to for support (Roalkvam, 2005 in Nkomo, 2006). Social isolation is also illustrated in a study conducted in Rwanda, amongst youth-headed households (Thurman *et al.*, 2006). In this study, 16% reported that they did not have anyone to turn to for any kind of support, and 86% reported feeling rejected by community members (Thurman *et al.*, 2006 in Nkomo, 2006). Thurman *et al.*'s study (2008) in Rwanda, identified poverty, family history, youth behaviour and NGO assistance as factors contributing to marginalisation of youth-headed households in communities. The inability of community members to adequately provide for their own families, constrained their capacity to support youth-headed households.

Destitution of children and youth living in child-headed households may also result in marginalisation. On account of their lack of proper clothing, soap, water and an adult guardian, children from these households may be shabby and untidy in appearance, which may lead to them being ostracised at school and in the community. This is evident in the study in Rwanda where youths were not invited to social gatherings because they did not have “presentable” clothing (Thurman *et al.*, 2008). In Haley and Bradbury's study (2015), children from child-headed households experienced animosity, negative stereotyping, hostility and suspicion within the community, with boys being regarded as dangerous, or engaging in criminal activities.

Some children are rejected by relatives after the passing away of their parents. In Ward and Eyber's study (2009), there were cases of children who had been rejected by both the maternal and the paternal extended families. This may be a result of family disputes, illegitimacy of children and stigma. Foster *et al.* (1997) note that children from single parents, may be neglected by relatives, as they are considered illegitimate (born out of wedlock). In Thurman *et al.*'s study (2008), youth-headed households were marginalised by the community as a result of past

disputes and the negative perceptions the community had of their parents. Children may also contribute to their own ostracisation because they feel inadequate and they do not fit in with their peers. As a result of the psychological distress they experience, children are also likely to be withdrawn and emotionally detached (Stein, 2003 *in* Thurman *et al.*, 2008).

Furthermore, bad behaviour by youths limited the willingness of the community to support them. Children and youths may engage in behaviour that is “unacceptable” in their community as a result of desperation and as a coping mechanism, which may include transactional sex and theft (Thurman *et al.*, 2008).

The mere absence of parents and adults in the household has social effects. Children learn behavioral and moral standards from parents through socialisation; children therefore lose opportunities for learning positive behaviour, and skills for survival, from family members (MacLellan, 2010). Societal norms, morals and values are not passed on to the children which could result in deviant behaviour, both as children and when they become adults (Kurebwa and Kurebwa, 2014).

Child-headed households may also be isolated as a result of external support from governmental and non-governmental organisations/development agencies. When support is targeted only at these households, it may create feelings of resentment within the community, which may weaken social networks, as community members withdraw their support to these households. In the study in Rwanda, community members did not support youth-headed households, as they felt these households were “rich” and better off than them, since they received support from an NGO (Thurman *et al.*, 2008). Youths in this study also reported that community members felt jealous of them (*ibid*) and were consequently ill-treated. Social capital and its networks and support are critical in reinforcing coping strategies and enhancing resilience of child-headed households (Awino, 2010).

#### *xi) Stigma, Abuse and Exploitation*

Being a rare and often misunderstood phenomenon in many communities, child-headed households are vulnerable to stigma and discrimination. Households formed as a result of

HIV/AIDS orphaning are particularly vulnerable. Consequently, children grow up at risk of neglect, violence and various forms of abuse (Bequele, 2007).

Studies have also shown that children living on their own are more vulnerable to higher risks of violence, abuse and exploitation, which ranges from rape by relatives and community members to transactional sex (Mullen and Flemming *in* Mabala, 2006). These children often experience loss of inheritance, fear and isolation and increased abuse (Maqoko and Dreyer, 2007). Those living alone are more vulnerable to property grabbing by relatives and communities with no adult to represent them. Walker's study (2002) in Zimbabwe had 40% of children reporting being abused since becoming a child-headed household.

### **3.3.4 Vulnerability and Resilience in Child-headed Households**

From the literature discussed, it is evident that children living in child-headed households are extremely vulnerable as they experience multiple deprivations and challenges (Geldenhuys, 2016; Foster *et al.*, 1997; Thurman *et al.*, 2006). Vulnerability refers to people's diminished capacity to cope, resist and recover from negative impacts (IFRC, n.d.); it is a state of being that relates to all life domains of an individual. A comparative study of children living in child-headed households and those living in adult-headed households, conducted in KwaZulu-Natal, points out that the nature of vulnerabilities and strengths of children living on their own are quite different from those of other vulnerable children (Donald and Clacherty, 2005).

In discussing the experiences and vulnerabilities of children in child-headed households, most studies fall short of providing the crucial holistic perspective, as they largely focus on one particular dimension of wellbeing, such as psychological wellbeing.

#### *i) Resilience and Agency*

Orphans, particularly those living in child-headed households, are often perceived as vulnerable, incompetent and in need of protection, resulting in their ability to manage their own lives often being overlooked (Francis-Chizororo, 2008). Skovdal and Daniel (2012) concur and argue that

research has heavily focused on children's victimisation, with little attention and appreciation of children's resilience in resource-poor and HIV ravaged settings. This construction of African children as vulnerable, has raised concerns of reifying vulnerability through creating untenable demands for OVC services, fostering a culture of relief aid.

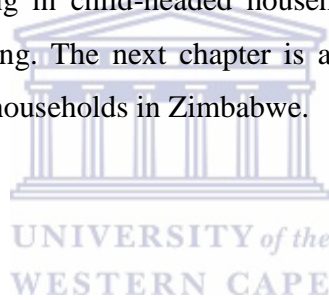
There is however, increasing evidence of children's agency. Agency refers to the possibility of children acting within their context (Vigh, 2008, *in* Lee, 2012). Honwana (2005) further classifies agency into "tactical agency" and "strategic agency". By virtue of being in a crisis situation, people are unable to plan for the long term, and thus respond by applying tactical agency through seizing an opportunity in the moment, to improve their wellbeing in the short term (Lee, 2012). Lee juxtaposes the different crisis contexts children are exposed to, and how they apply tactical agency, citing child soldiers surviving in northern Uganda, civil war in Liberia and youths in shanty towns in Brazil.

Grotberg (1995 *in* Ward and Eyber, 2009: 19) defines resilience as "the human capacity to face, overcome and be strengthened by or even transformed by, the adversities of life". Masten and Coatsworth (1998) similarly define resilience as the manifested competence in the face of significant challenges to adaptation or development. Daniel (2013) employs Luthar *et al.*'s (2001: 1) definition of resilience, "a dynamic process of positive adaptation within the context of significant adversity". The resilience of child-headed households can be seen when children strive to care for their siblings and creatively seek solutions to their challenges (Lee, 2012).

Skovdal and Daniel (2012) review pathways leading to children's resilience; this pathway is composed of children's interaction with their social environment. Skovdal and Daniel (2012), stress that the actual interface between the individual and the environment is the core of an individual's resilience. Ungar (2008) goes further and states that the outcome of the pathway is influenced by the individual's capacity to navigate in their environment, as well as the conditions of the environment. The social environment in which child-headed households are located, therefore not only creates vulnerabilities and risks for children, but also provide opportunities that enable resilience.

### 3.4 Summary

This chapter considers the various definitions and typologies of child-headed households and provides a discussion of the formation, constitution and dynamics of these households. It included an extensive review of the experiences of orphans. Literature has shown that orphans experience challenges of food insecurity, poverty, psychological distress, poor health outcomes and social isolation. In addition to these challenges, orphans living in child-headed households experience additional psychological distress, as a result of parentification and conflicting roles, and are vulnerable to various forms of abuse arising from the absence of an adult in the household. These orphans' experience exacerbated deprivation, as they are the sole breadwinners of the households. There is, however, evidence that children in these households are not only active agents, but are resilient. There is however, a dearth of literature on the holistic perspective of the wellbeing of orphans living in child-headed households, as most studies explore one aspect of these children's wellbeing. The next chapter is an empirical chapter presenting the situation analysis of child-headed households in Zimbabwe.



## **CHAPTER 4**

### **SITUATION ANALYSIS OF CHILD-HEADED HOUSEHOLDS IN ZIMBABWE**

#### **4.1 Introduction**

Although a few studies on child-headed households (CHHs) have been conducted in Zimbabwe, there is insufficient information on the number of child-headed households, where they are located, their challenges as well as policy responses to their plight. This study therefore, started with a situation analysis to understand the nature and local perceptions of child-headed households in Zimbabwe.

This chapter begins by presenting the methodology used in the situation analysis; followed by a discussion of the factors influencing the establishment of child-headed households. Stakeholder perceptions of the challenges experienced by orphans living in these households are presented. The final section of this chapter discusses the policies, programs and interventions supporting child-headed households in Zimbabwe.

#### **4.2 Methodology**

A focused situation analysis of child-headed households in Zimbabwe was conducted between May and August 2013. The aim of the situation analysis was to describe the experiences and challenges of children living in child-headed households in Zimbabwe, as perceived by key stakeholders.

### 4.2.1 Study Design

A focused situation analysis was conducted. A *situation analysis* is a comprehensive review of the circumstances at hand that provides an understanding of the contextual factors (Vann, 2002). Furthermore, it identifies significant issues requiring attention. It is also referred to as formative research or context analysis. The International Union for Conservation of Nature (IUCN) (*n.d.*) defines a situation analysis as a scoping and analysis of the broad context or external environment within which a project operates. The current project assesses quality of life of orphans living in child-headed households in Zimbabwe and explores factors influencing quality of life. In this instance the broad context includes the macro-economic and structural environments (such as housing, water and sanitation) that child-headed households live in, as well as the social protection mechanisms available to them.

The objectives of a situation analysis generally include, but are not limited to:

- defining the nature and extent of the problem in the local context;
- mapping the perceptions and experiences of key stakeholders in relation to the problem;
- identifying existing strategies which address the problem;
- identifying key actors in the problem;
- identifying gaps in existing strategies and interventions.

The focus of the current situation analysis was to gain insight and familiarity of the conditions and experiences of orphans, living in child-headed households in Zimbabwe, as a starting point for in-depth investigation. With this in mind, the situation analysis took the form of an exploratory qualitative approach. Brown (2006: 43) points out, that exploratory research investigates areas with little or no research previously done. It was therefore fitting to use an exploratory qualitative approach in conducting the situation analysis of orphans living in child-headed households in Zimbabwe, as this is an under-studied area (Francis-Chizororo, 2008). Furthermore, an exploratory approach was selected to identify specific areas for further inquiry in the subsequent study phases.

The IUCN model for conducting a basic situation analysis was preferred for this study over other methodologies, such as Clarke's (2005) situational analysis method, as it is more structured and

rigorous and provides steps that can be replicated. Furthermore, the IUCN model allows for an analysis of issues, trends and stakeholders, influencing the wellbeing of children living in child-headed households. The IUCN model therefore enables the analysis of all critical factors which may otherwise be omitted.

The model consists of 8 steps:

- i) define the boundaries of the areas to be included in the analysis;
- ii) research and describe the state and condition of people and the ecosystem;
- iii) identify trends, pressures, driving forces and responses;
- iv) discuss the analysis and identify the major significant issues requiring attention;
- v) choose the most appropriate issues for IUCN;
- vi) identify stakeholders;
- vii) assess stakeholder interest, influence and importance;
- viii) design stakeholder participation strategy.

For the purposes of this study, only steps i – iv were applied as the study was not action research and did not have an intervention stage that would require the identification and involvement of stakeholders.

Step I: Define the boundaries

Step I entailed delineating the area to be covered by the analysis, the area selected was Zimbabwe. This was informed by the boundaries of the overall study, which is the situation or condition of children living in child-headed households in Zimbabwe.

Step II: Describe the state and condition of people

The second step entailed researching and describing the state and condition of people and the ecosystem; an exploration of the conditions and experiences of orphans living child-headed households was therefore conducted. The suggested human dimensions of health and population; wealth; knowledge and culture; community; and equity were explored. These all overlap with the WHO Quality of Life (WHOQOL) framework domains, the study's analytical framework. A description of the dimensions is presented in table 4.1 below.

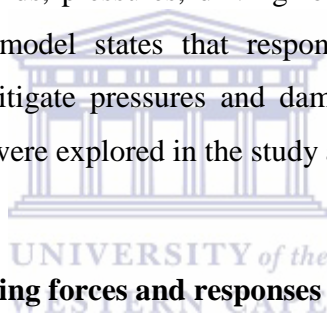


**Table 4.1 Dimensions for describing human conditions**

<b>Dimension</b>	<b>Issues</b>
Health and Population	Physical and psychological health of orphans
Wealth	Income, basic needs:– food, water, clothing and shelter
Knowledge and culture	Education, access to information
Community	Community support, attitudes
Equity	Distribution of social welfare benefits

Step III: Identify trends, pressures, driving forces and responses

In accordance with the model, trends, pressures, driving forces and responses to child-headed households were explored. The model states that responses are policies and programmes intended to prevent, reduce or mitigate pressures and damage at local, national, regional or global level. Particular issues that were explored in the study are listed in table 4.2 below:

**Table 4.2 Trends, pressures, driving forces and responses to child-headed households**

<b>Dimension</b>	<b>Guiding questions</b>	<b>Element/Issues</b>
Trends	How have child-headed households in Zimbabwe evolved over time?	Magnitude and existence of child-headed households in Zimbabwe
Pressures	What pressures are generating these changes?	Factors leading to the establishment of child-headed households
Driving forces	What are the driving forces?	
Responses	What are the responses to child-headed households locally and nationally?	National programmes and community interventions

Step IV: Identify major significant issues

Once these issues were identified, a discussion and reflection process emerged, through thematic data analysis. Significant issues to be further investigated, were highlighted. All issues highlighted were taken forth in the subsequent phases.

#### **4.2.2 Study Population and Sampling**

The study population consisted of stakeholders, working in the area of orphans and vulnerable children at implementation level or at national levels. Expert sampling was used to select these stakeholders. This is a type of purposive sampling technique where individuals with knowledge and expertise on the research area or subject are purposively selected (Singh, 2007). The study sample comprised of ten key informants from the Department of Social Services and Child Protection, Social Welfare, local NGOs, schools and Child Protection Committees (CPCs).

#### **4.2.3 Data Collection**

Data were gathered using semi-structured interviews (10), focus group discussions (2) and a document review. Gill *et al.* (2008) indicates that interviews are most appropriate where little is known about a study phenomenon. Semi-structured interviews were therefore selected, as greater depth of responses was required, seeing that there was a dearth of information on the wellbeing of child-headed households. Focus group discussions were conducted with Child Protection Committees from Chegutu and Kadoma. Focus groups are particularly useful in obtaining several perspectives on the same issue (Gibbs, 1997), as the group dynamics stimulate conversation and reactions, bringing out information that may not have emerged from other data collection methods. Similarly, Morgan and Krueger (1993 *in* Morgan, 1997) point out, that the comparisons of experiences and opinions that participants make amongst each other, are a valuable source of insight. This phase was exploratory thus, the combination of semi-structured interviews and focus group discussions provided multiple perspectives. Focus groups were also employed to triangulate findings from the interviews thereby enhancing trustworthiness of the findings.

Policy papers, programme reports, journal articles and grey literature were obtained from the internet. These included programme documents under the National Action Plan for Orphans and

Vulnerable Children II as well as reports from non-governmental and international organisations. Additional programme documents were identified through consultation with key stakeholders.

Interviews and focus group discussions were conducted by the researcher, with the support of a research assistant, who had received training on the study objectives, semi-structured interviewing and research ethics.

#### **4.2.4 Data Analysis**

Data were analysed thematically for emerging themes, as well as *a priori* themes, derived from the WHOQOL framework. This framework was also employed as the analytical lens for data analysis. This means that results were interpreted in relation to the four WHOQOL domains of physical, psychological wellbeing, social relationships and the environment.

Firstly, credibility was ensured through triangulation in data collection, with stakeholder interviews, focus group discussions and review of documents. Secondly, recognising the potential limitations of some data sources such as newspapers, credibility was also ensured by reviewing various sources to check consistency of events and policies. Furthermore, steps were taken to validate authorship of documentation. Thirdly, dependability was ensured, by providing a transparent and clear description of the methodology employed in conducting the situation analysis, showing how findings were obtained. Fourthly, to increase the truth value of data, all interviews were audio recorded which enabled repeated revisiting of recordings to confirm emerging themes. In the final phase of the study, stakeholders were invited to comment on findings of the situation analysis as recommended by Noble and Smith (2015).

To achieve external validity in qualitative research, Lincoln and Guba (1985) recommend thick descriptions. Themes emerging from the situation analysis are therefore described in great detail. A thick description of the context of the situation analysis was provided to enable transferability of findings to other settings.

### 4.3 Findings

This section presents the findings and interpretation of the situation analysis. The findings encompass stakeholders' perceptions of the situation of child-headed households, as well as an analysis of policy and programmatic responses for child-headed households in Zimbabwe. Documents reviewed are listed in table 4.3.

**Table 4.3 Documents reviewed for situation analysis**

<b>Document</b>	<b>Authority</b>	
Zimbabwe Country Brief 2011- 2013	African Development Bank	Macro-economic context
Zimbabwe Country Report 2011	African Economic Outlook	Macro-economic context
Zimbabwe Vulnerability Assessment Committee Report 2016	Zimbabwe Vulnerability Assessment Committee	Food security situation
National Action Plan for OVCs II	Ministry of Public Service, Labour and Social Welfare	Social protection services
Social Protection in Zimbabwe	Chitambara, P. Labour and Economic Development Research Institute of Zimbabwe	Social protection services
UNICEF Zimbabwe Annual Report 2011	UNICEF	Challenges experienced by orphans
UNICEF Situation Report 2012	UNICEF	Socio-economic context
National Case Management System	Ministry of Public Service, Labour and Social Welfare	Social protection services
Education Transition Fund	UNICEF	Social protection services

### 4.3.1 Context: Zimbabwe as a Fragile State

Zimbabwe is a fragile state experiencing conditions of socio-economic and political vulnerability. A fragile state is a country “where the state power is unable and/or unwilling to deliver core functions to the majority of its people: security, protection of property rights, basic public services and essential infrastructure” (Organization for Economic Co-operation and Development, 2008). Although Zimbabwe has not been at war, in the past two decades it has experienced “war-like” trauma. Since 2000 the country has been facing a series of unprecedented political and economic challenges, namely economic instability, food insecurity, collapse of the health system and failure to provide basic services (Makochekanwa and Kwaramba, 2009).

Zimbabwe’s economy spiraled from one of Africa’s strongest to one of the world’s most impoverished. Since 2000, it has become one of the fastest shrinking economies globally with hyperinflation figures reaching an estimate of 6.5 quindecillion novemdecillion percent<sup>1</sup> in July 2008. GDP growth was only 1.5% in 2015, a decline from 3.5% in 2014 (African Development Bank, 2016). The economy was largely affected by the Fast Track Land Reform Programme and the Operation Murambatsvina. The Fast Track Land Reform Programme aimed at redistributing land to black Zimbabweans. This resulted in a devastating drop in total agricultural production, subsequently affecting the manufacturing sector, export markets and the country’s food basket. Consequently, unemployment and poverty are endemic. Poverty and unemployment were exacerbated by the infamous Operation Murambatsvina, a slum clearing and “urban beautification” project, designed to eradicate illegal housing and informal economic activities. 4 million Zimbabweans lost their livelihoods and an additional 4 million dependents were affected (UNICEF, 2005).

According to the World Bank, Zimbabwe’s national poverty headcount ratio, which is the percentage of the population living below the national poverty line, was at 72% in 2011. In July 2016, the Food Poverty line was at US\$30 per person and US\$151 per household with an average of five members (ZimStat, 2016). The Total Consumption Poverty Line was at US\$480 per household for the same period, this is the minimum amount required for food and non-food items for a household to be considered as not poor (ZimStat, 2016).

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<sup>1</sup> 65 followed by 107 zeros, Makochekanwa and Kwaramba, 2010.

The economic crisis fueled food shortages leading to what has been referred to (by donors and international press), as a “desperate humanitarian crisis”. Recurrent droughts, exorbitant food prices, high unemployment and lack of purchasing power have increased levels of acute food insecurity (WFP, 2016). It is anticipated that over 4 million people will need food assistance between January and March 2017 (ZimVAC, 2016).

As the economy declined and government expenditure reduced, the budget allocations for health, education and social welfare were also cut. This reduction of healthcare funding affected the quality of services in public facilities at all levels. The health system faces challenges of shortage of essential medicines and supplies, eroded infrastructure and shortage of skilled healthcare professionals. An example that depicts the malfunctioning of the health system is that a pregnant woman, delivering, had to bring her own supplies of 15 pairs of gloves, a peg for the umbilical cord, a candle for night delivery, 20 litres of water, cotton wool and soap (Physicians for Human Rights, 2009). Furthermore, the country continues to experience a heavy burden of disease including HIV/AIDS, malaria, tuberculosis and diarrhoeal diseases.

Children are the hardest hit by this economic instability (UNICEF, 2015). One third of Zimbabwe’s children are stunted and only 11% of children between 6 - 23 months receive a minimum acceptable diet. Severe Acute Malnutrition (SAM) rate for children aged 6 - 59 months was 2.1% which is slightly above the country’s emergency response threshold of 2% and Global Acute Malnutrition rate of 5.7% in 2016 (ZimVAC, 2016). *The Child Protection Rapid Assessment Report 2016* indicates an increase in child neglect, child labour, sexual exploitation and physical abuse (ZimVAC, 2016).

Programmes, such as the fast track land reform and operation Murambatsvina, disrupted children’s education, as many parents had lost their livelihoods and could not afford to return their children to school. In addition, families were relocated to places with no schools. Furthermore, the education system also suffered a massive brain drain, as trained teachers migrated to nearby countries for economic sanctuary. According to Makochehanwa and Kwaramba (2010) more than 18,000 teachers migrated from Zimbabwe between 2000 and 2006. In January 2010, there were only 80,000 working teachers in the country, 60,000 short of the required 140,000 for the Education system to function efficiently. With no teachers and no funds to pay them, government schools

were closed the entire academic year of 2008. According to UNICEF, 94% of rural schools were still closed in February 2009. As a result, many children missed a whole year of school.

Social Protection systems serve as safety nets in times of distress particularly for vulnerable population groups; however, the collapse of the country's social protection meant that children's access to health, education and wellbeing would not be safeguarded. The Zimbabwe National Council for the Welfare of Children (2010) stress that during this period there were no efforts by the Government to promote and protect children's rights. "Zimbabwe's fragile political and economic environment is leading to increased deprivation and causing some children to move, often unaccompanied within the country and region" (UNICEF, 2010b: 4).

Characteristic of a fragile state, Zimbabwe has failed to provide essential services such as water, electricity, waste management, housing and roads. Consequently, this has led to a series of cholera and typhoid epidemics with 98,500 cholera cases and over 4,000 cholera deaths by June 2009 (WHO, 2009) and 1,680 cumulative typhoid cases in 2016 (UNICEF, 2016).

#### **4.3.2 Existence of Child-headed Households in Zimbabwe**

Respondents confirmed that child-headed households do exist in many communities, however, no one was able to quantify the prevalence of these households. One respondent indicated that there are a substantial number of children living in child-headed households but was unable to quantify this number. Arising from interventions, such as family tracing, the numbers are reducing in some areas. Another respondent indicated that although moderate, the phenomenon of child-headed households is a problem; however, he pointed out that figures were reducing, as the orphans are eventually absorbed by their extended family. This respondent also indicated that a child-headed household is normally formed for a short period, usually after parents pass away, and then the household dissolves when the relatives take the children in. Another respondent alluded to accompanied child-headed households, pointing out that although child-headed households do exist, most orphans live with their grandmothers, who are old and frail and unable to look after themselves let alone care for the orphans:

*Other orphans only have elderly grandmothers, even though they move in with, the child ends up taking care of the grandmother who is too old or too sick to look after the children. That is why we say these households are still child-headed households.*  
(Female - Rural, FGD 1)

### **4.3.3 Factors leading to the Establishment of Child-headed Households**

According to respondents, there are various factors leading to the establishment of child-headed households; these include migration of parents, poverty and weak kinships in communities.

#### *i. Migration*

Respondents indicated that given the current economic turmoil in Zimbabwe, most child-headed households are formed when parents migrate. Owing to high unemployment and widespread poverty in Zimbabwe, many people are migrating in search of employment to South Africa, Botswana, the United States of America and the United Kingdom. These type of households, are supported as children receive remittances from parents and are often temporary as children eventually follow their parents. Respondents indicated that some of these child-headed households are better off/wealthier than adult-headed households in the country, as they have a regular source of income. A respondent remarked:

*...you find that these children are better dressed than our own children and they do not experience challenges such as food shortages* (Female - urban, Interview).

In addition, arising from the massive exodus of Zimbabweans, the extended family network has been weakened and when parents migrate, there may be no close relatives with whom to leave the children.



### *ii. Poverty*

With the incessant socio-economic challenges in Zimbabwe, many communities have been ravaged by poverty, droughts and HIV/AIDS, diminishing their capacity to support vulnerable groups such as child-headed households. Respondents indicated that owing to unemployment and poverty, many relatives are unable to support orphans. Some households are not able to afford the extra mouths to feed and additional school fees, while other households may not have space to accommodate these orphans. Most of these relatives are living in dire poverty themselves and are unable to support these child-headed households. A respondent remarked:

*It's like in a sinking ship where two people are drowning, obviously, it will be one man for himself because there is no way I can rescue you when I'm drowning myself* (Male - urban, FGD 2)

Relatives therefore often prefer to support and check up on the child-headed households, without taking them in.



### *iii. Weak Kinships*

When parents pass away and there are no relatives to take in the children, they are left to live on their own. When parents divorce or separate and the remaining parent passes away, sometimes children are not able to track the other parent and end up living as child-headed households.

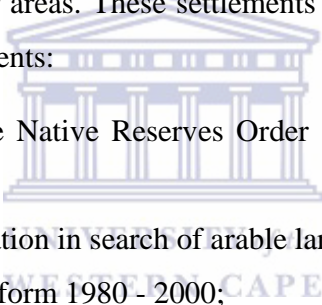
From interviews and informal discussions with local community members, it became evident that in some rural communities, the concept of child-headed households did not exist as there were no such households; while in other communities child-headed households were burgeoning. Further investigation was then conducted to explore why communities, that seemed homogenous, had differences in the occurrence of child-headed households.

The occurrence of child-headed households in rural communities is influenced by the community's kinship ties. "Organic" communities, with strong kinship ties, made up of extended families living in clans, had fewer child-headed households. In these communities, there is no such thing as an orphan, everyone has a family and when parents pass away the extended family

takes in children left behind. However, in less organic communities, where families were unrelated and of different kinships, child-headed households were prolific. Families had moved away from their original clan settlements and resettled elsewhere. In these mixed settlements, when parents pass away, there is often no relative within the community to take in the children. This is the case in the Shona culture, as it is not common to adopt or take in a child of a different clan and therefore orphans end up living on their own.

The strength of a community's kinship ties can be traced to the way the community settled, whether it settled as clans or as individual families forming a *mélange* of clans. Zimbabwe has a rich history of rural land resettlement patterns, stretching from pre-colonial settlements to the recent land reform resettlements, with some settlements more organic than others.

As with most African rural settlements, rural communities in Zimbabwe originally settled as clans in their separate territories or areas. These settlements were, however, later disrupted as a result of four major resettlement events:

- 
- i) Forced relocation under the Native Reserves Order 1898 and the Land Apportionment Act of 1930;
  - ii) Large scale voluntary relocation in search of arable land between 1960-1980;
  - iii) Post-independence Land Reform 1980 - 2000;
  - iv) Fast Track Land Reform Programme 2000 - 2008.

The first resettlement structure is that of the traditional rural reserves that formed as a result of colonisers, settling on prime land and relocating native blacks to the Native Reserve Areas under the Native Reserves Order and the Land Apportionment Act of 1930. These traditional reserves are now known as Communal Areas. Initially they were called Tribal Trust Lands, indicating the emphasis on tribal settlements. Families were moved as entire clans, with their neighbours and extended families and settled together thereby retaining their clan structure. Settlements formed this way include Mhondoro-Ngezi, Murehwa and Mutoko. In this settlement structure, child-headed households are less likely to form because of strong kinship and community ties. All households in these communities are related to each other in some way, so that when children are orphaned, there is an uncle or aunt to absorb and/or support them.

With time, these Tribal Trust Lands became overcrowded and land and resources became limited; as a result, there was a lot of mobility between 1960 and 1980, with families relocating voluntarily to virgin unpopulated lands. These areas were arid Malaria and Tsetse fly infested and had been marked as unfit for human settlement by the colonial government. There were two types of settlers. Individuals and families were the first type who moved away from their communities in search of the *El Dorado*<sup>2</sup> of rich arable land that would increase their wealth. The second type of settlers were marginalised and outcast individuals and families, that were either banished by the chief or rejected and shunned by their clan for various reasons such as being accused of witchcraft or theft. These communities are not settled as clans, rather as families with different kin, tribal and ethnic backgrounds. This settlement structure is found in the area stretching from Gokwe, Sanyati, Binga to the Zambezi Valley. Child-headed households seemed to be more common in these areas.

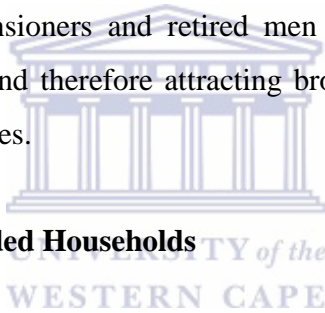
Following independence, the Government sought to redress this racially skewed land distribution pattern where 6,000 white farmers owned over 15 million hectares of commercial farms, which is 45% of the country's agricultural land. This post-independence Land Reform programme also sought to relieve pressure on the crowded communal areas and to give land to poor landless black people. Land acquisition was on a "willing seller, willing buyer" basis, whereby the Government was purchasing land from white farmers and resettling natives as stipulated in the Lancaster House Agreement, signed at Independence between the Governments of Zimbabwe and Britain. As a result, resettlement was not community based; instead, individual families received land, thus increasing the tribal heterogeneity initiated by the voluntary relocation discussed above.

After the expiry of the Lancaster House Agreement in 1990, the Government maintained the "willing seller, willing buyer" policy and slowed down purchasing land, because of economic constraints, which included the 1992 drought and the International Monetary Fund (IMF) and the World Bank sponsored Economic Structural Adjustment Programme (ESAP) (Lebert, 2006). War veterans started to seize and occupy white owned farms in 1998, impatient of the land reform programme that had become lifeless. This forced the government to accelerate its land reform programme, and in 2000, the government embarked on the Fast Track Land Reform

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<sup>2</sup> A place of immense wealth. The tale of El Dorado is about Europeans in the 16<sup>th</sup> century journeying in search of a city of gold. Sir Walter Raleigh journeyed in search of El Dorado in 1617.

Programme, an extensive compulsory land acquisition and redistribution of white commercial farms and private companies. 160,000 families were settled in large-scale commercial farms previously inhabited by 4,000 white farmers (Gonese et al., 2002). The land allocation process resettled individual households from different places, clans and socio-economic backgrounds and did not prioritise settling people of the same lineage and clan group on the same farm thus “strangers resettled together”. This resulted in communities, with socially differentiated households and some authors claim this resettlement led to the “emergence of conflict ridden communities”. These new resettlements are therefore different from the communal areas and the 1980 resettlement schemes. With this mix of people, there are no reciprocation ties that characterise lineage and kinship settlements, thus there were more child-headed households as the children do not have relatives in the area to absorb them. The resettlements are also plagued by numerous socio-economic challenges namely poverty, unemployment and HIV/AIDS. Initially, settlers were largely pensioners and retired men with wives working in the cities, analogous to mining settlements and therefore attracting brothels and prostitution. As a result, HIV has scourged these communities.



#### **4.3.4 Experiences of Child-headed Households**

Findings indicate that children living in child-headed households experience numerous challenges. They have poor quality of life and live in deplorable conditions, characterised by poor housing, poor health, food scarcity, and experience psychological problems. A respondent expressed that:

*They are the most uncared for and unlooked after group in the country at the moment because the shift that has happened both politically and economically have totally ignored the needs of child-headed households (Female - urban, Interview).*

Findings also indicate that children from child-headed households also have positive experiences as they receive support from communities and reveal some resilience.

*i. Poor Health*

In the WHOQOL framework, the physical domain encompasses physical pain and discomfort, sleep, rest and energy to perform daily tasks. Results indicated that the physical wellbeing of children living in child-headed households is compromised, because of the absence of an adult supervisor, food insecurity, lack of sufficient funds, to access healthcare services as well as engaging in hazardous and strenuous livelihood activities. The absence of an adult supervisor in the household could result in poor judgement, in terms of health-seeking behaviours such as poor food choices, food handling, eating habits and when to seek medical attention. The latter was reported as being common amongst child-headed households as a respondent pointed out:

*Health is determined by income, because normally for child-headed households the first preference is provision for food and health becomes a second priority (Male – urban, interview).*

Financial insecurity in child-headed households was considered a contributory factor to poor health in several ways; the lack of funds often translates into food insecurity, resulting in malnutrition. The lack of funds also means that children cannot afford to go a clinic or hospital when they fall ill. Respondents indicated that this was the case in many households that had children who were living with HIV and could not afford antiretroviral treatment as well as the nutritious food required. As a result, children experience deteriorating health with some even dying. As a respondent expressed:

*Some of these children were left orphans by parents due to the HIV virus and some of them were left positive and this will negatively affect them because in as much as we encourage them to take the pills they end up not taking any pills because of lack of food. These pills require a person to eat and because of the difficulties they face in getting food they stop taking their medication and this is when you find them sitting at the same house, falling sick (Male urban, interview).*

Children's physical health is also affected by the strenuous livelihood activities they engage in; respondents indicated that children as young as seven years old work in plantations and irrigation schemes which are often labour intensive requiring long working hours.

The role of the living environment on children's physical wellbeing, a critical factor influencing children's health, surprisingly did not emerge from the fieldwork. For example, poor sanitation particularly poor sewerage and solid waste disposal could expose children to diseases such as dysentery, cholera and typhoid.

*ii. Psychological Distress*

Respondents indicated that children living in child-headed households experience numerous psychological challenges. A respondent pointed out that:

*The psychological effects are many, many of these children need counselling because some become suicidal thinking if their parents were still alive things would be better* (Female - urban, interview).

These psychological challenges result from parental loss, stigma, hopelessness, new responsibilities and the stresses of financial insecurity, food insecurity as well as feelings of unsafety. Furthermore, the lack of social support exacerbates children's psychological distress. The experiences of parental illness and death can be psychologically devastating and if not addressed can have long term effects on children as they develop into adults.

Linked to parental illness and death is stigma amongst relatives and the community; respondents noted that many child-headed households were stigmatised within their communities, particularly if their parents died of HIV related illnesses. This has also resulted in relatives refusing to take in these children. Children are left feeling rejected and unwanted, which could lead to other psychological challenges such as depression.

The new roles that children are faced with as members of child-headed households could be quite daunting and be a cause of great psychological distress. One respondent remarked that:

*...if you were relying on a parent and now you are the parent, it means in terms of our Zimbabwe situation where adults are even struggling to get employment, being a minor who's the breadwinner, it means you face great challenges, in such a way that it strains the mind* (Female – urban, interview).

One respondent indicated that these psychological problems are often a learning barrier and as a result, children struggle with school and eventually drop out. After dropping out, these children lose contact with their friends from school, which exacerbates their psychological distress. These children are said to become withdrawn and anti-social, exhibiting depression and suicidal symptoms.

*iii. Social support*

It is the perception of stakeholders, that on the one hand, child-headed households receive a lot of support from the community while on the other hand, these children are isolated and abandoned by their relatives. Social relationships are of valuable importance to child-headed households, as these are part of their safety nets contributing to their survival strategies. The extended family in particular, is a critical social support pillar for child-headed households. According to respondents, many child-headed households depend on relatives for food, livelihood and financial support. In Chegutu rural, child-headed households were assisted by their relatives in ploughing their fields while other children received *maricho*<sup>3</sup> opportunities from their relatives. It was also noted that some children were receiving support for school fees from their relatives.

Respondents highlighted that most communities are aware of the challenges of child-headed households and are sensitive to them. Some community members tried to locate children's relatives, in order to integrate them. Other communities have initiatives to support child-headed households. A respondent remarked:

*Then the community itself supports the children, they give to these children, in the C area, people used to contribute every month, maize-meal, food etc for that family*  
(Female, FGD 2).

Respondents also pointed out the important and supportive role that, neighbours of child-headed households play. In the absence of an adult household member, neighbours informally take on the guardianship role for these children, watching over them and assisting where possible either

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<sup>3</sup> Maricho is performing menial tasks in exchange for small cash payment



with food or material support. However, this varies and is dependent on the willingness of neighbours. An example from a respondent:

*I have a case where the landlord did not evict these children because she said if she were to evict them then they would have nowhere to go so she took them in and takes care of them at times (Female – urban, interview).*

In some cases, these relatives become opportunists and take from these child-headed households. Respondents alluded to cases where relatives appropriated property that children had inherited from their deceased parents. In one case, a respondent stated that relatives were leasing out the child-headed household's home and taking the income for themselves.

Furthermore, the lack of adult mentorship and support for children living in these child-headed households was stressed. Respondents' perceptions were that many children from child-headed households engage in deviant behaviour and illegal activities arising from lack of proper adult guidance and mentorship. Children are learning norms and values from outside the home and may be acquiring deviant norms. Loss of friends as a result of dropping out of school and engaging in livelihood activities further reduces children's social support.

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#### *iv. Food Insecurity*

Food insecurity is a major and cross-cutting theme that surfaced in various dimensions of children's wellbeing, notably physical health and social relationships as discussed above. It is one of key challenges experienced by children in child-headed households and worth further discussion. All respondents pointed out that food insecurity is a huge challenge for child-headed households. As a result of low household income, children often do not have enough food supply and feed on whatever they can find. It is particularly a problem for children on Antiretroviral therapy (ART) as they end up defaulting because of lack of food. Their health deteriorates and some children are said to have died. Similarly, children drop out of school, as they cannot go to school hungry and need to engage in livelihood activities in order to provide food for their siblings. A respondent noted that food shortages in child-headed households, was a challenge, as children failed to concentrate and were often weak and inactive because of hunger.

In urban areas, food insecurity is a larger challenge for child-headed households, as all food commodities are purchased; unlike in rural settings where children can grow vegetables and can trade their labour for food. As previously discussed, most child-headed households rely on food from neighbours, well-wishers and food hampers from NGOs.

As a coping strategy, children also engage in *humwe*, which is a practice in many rural settings in Zimbabwe, whereby people plough and cultivate fields in exchange for food. From observations, children often received maize, maize-meal or a plate of food as payment. On other days they received tomatoes which they would have to sell to get money to buy other food. However being a rural area where many people grow their own produce, tomatoes were not a lucrative commodity so some children would spend the night without food. In Mhondoro, children working at the Mamina Irrigation Scheme, received food parcels such as tomatoes and maize, which helped reduce household food insecurity.

#### v. *Dropping out of School*

A recurring theme was that many children in child-headed households dropped out of school. Children drop out of school because of the lack of school fees, the need to engage in livelihood activities and caregiving responsibilities at home. Without an economically active adult, many children living in child-headed households cannot afford school fees and consequently drop out of school. In some cases, older children drop out to earn money to keep their siblings in school. Although there is an education support programme for vulnerable children, many children from child-headed households are not on this programme.

Respondents also indicated that children drop out of school to engage in income generating activities. In the rural areas, however, children struggle to earn income as income generating activities are limited. Respondents indicated that older children drop out of school to look after younger siblings and to perform household chores.

#### vi. *Access to health services and sanitation*

Accessing health services is a concern for many OVCs. Many children in child-headed households do not go to healthcare facilities when they are ill or need medical attention. These

children do not seek healthcare for a number of reasons: lack of knowledge about the infection and where to get help; lack of funds to travel to health facilities; lack of funds for treatment and medication; lack of relevant documentation needed for treatment such as birth certificates. Children living alone are often in poor health, as they do not seek medical treatment for small infections and illnesses, which later develop into serious illnesses.

Like other Zimbabweans, access to water and sanitation is a challenge for child-headed households; it is particularly difficult for younger children who have to fetch water long distances away from the homestead.

#### *vii. Failure to Obtain Birth Certificates*

In Zimbabwe, birth certificates are required to access many services, such as health care and to sit for Grade seven examinations. The department of Social Services official indicated that many children living in child-headed households do not have birth certificates. Many orphans face the challenge of obtaining birth certificates after parents have passed away; this is particularly difficult for children living in child-headed households who often do not have relatives able or willing to assist them. The main problems children encounter, are firstly, they do not have enough information on how and where to obtain birth certificates. The director of Simbarashe indicated that many OVC are not aware that obtaining a birth certificate is their right. Secondly, they often do not have the required documentation such as parents' birth and/or death certificates. Thirdly, identity documents such as birth certificates, ID and passports are difficult to obtain and minors are often required to be accompanied by an adult relative. This may not be easy for child-headed households, as some are neglected while others lack committed relatives. The procedure requires a committed person willing to spend long hours queuing repeatedly at the issuing offices, often for days.

#### *viii. Vulnerability to Abuse*

By nature of living alone without an adult, child-headed households are vulnerable to risks and abuse of all kinds. One of the interview respondents shared a scenario, where local officials had to intervene after a young girl, living with her siblings had been continually raped by men in the

neighbourhood, as they were aware of the absence of an adult in the household. Local officials stepped in and the girl was taken to a place of safety. Another scenario presented, was of a child-headed household where strangers took all the furniture and threatened to kill the children if they told anyone. The children watched helplessly.

#### **4.3.5 Social Protection: National Policy and Programme Responses in Zimbabwe**

To address these challenges, the Government of Zimbabwe has a broad range of social protection mechanisms and the National Action Plan for Orphans and Vulnerable Children specifically focuses on orphans and vulnerable children.

Social Protection programmes seek to reduce the vulnerability of poor and people at risk in a society. Zimbabwe has a range of social protection programmes, many that were instituted before the macro-economic crisis. Social protection programmes, specifically relating to child-headed households were investigated. Masuka *et al.* (2012) loosely define social protection as protection that a society provides for its vulnerable member and Manjengwa (2008) defines it as mechanisms to protect citizens against livelihood risks while promoting livelihoods and capabilities of the vulnerable and enhancing the social status and rights of the marginalized. Social protection mechanisms can be categorised into three groups: social insurance, labour - market regulation and social assistance. Under the auspices of the Ministry of Labour and Social Services, the government of Zimbabwe employs the social assistance approach, providing support to deprived citizens.

There are a number of social protection schemes administered by the department of Social Services as mandated by the Social Welfare Assistance Act, 1998. The Schemes include elderly and disability grants, provision of health assistance, pauper burials, grain loan schemes, free food distribution and drought relief. The schemes target deprived and destitute households and citizens. However, arising from economic challenges, many Zimbabweans are currently vulnerable and large numbers fit in the “destitute” category, qualifying them for public assistance according to the programme’s broad parameter.

Child-headed households are eligible for health assistance and drought relief support under this programme. The Health assistance scheme provides free medical treatment to citizens unable to

afford health services, while the drought relief provides food parcels to deprived households in drought and times of food scarcity.

Social protection interventions for OVCs in Zimbabwe have evolved over time with some being replaced by new and more effective strategies; these have been integrated into the National Action Plan for Orphans and Vulnerable Children. These schemes will be discussed as follows. A list of all social protection programmes for OVCs is presented in table 4.4.

**Table 4.4 Social protection mechanisms offered to OVCs in Zimbabwe**

<b>Mechanism</b>	<b>Services rendered</b>
Harmonised Social Cash Transfer	Cash transfer for vulnerable households
Basic Education Assistance Module	Tuition support for vulnerable children
Child Protection Services	Monitoring and implementing child protection interventions
Assisted Medical Treatment Orders	Fee waivers for secondary and tertiary healthcare services for vulnerable people
Second Chance Education programme	Learning opportunities for out of school children and youth
Zunde raMambo	Indigenous food security strategy for vulnerable households

*i. Enhanced Social Protection Project*

Launched in 2000, the Enhanced Social Protection Programme (ESPP) is a government social protection strategy that is considered to be one of the best social protection systems in Africa (Schubert, 2010). Components of ESPP include the Basic Education Assistance Module (BEAM), Public Works, Children in Especially Difficult Circumstances (CEDC) and Essential Drugs and Medical Supplies (EDMS) programmes. These are discussed in detail under the National Action Plan for Orphans and Vulnerable Children. ESPP was externally funded and as economic and political instability heightened and the country's international relations deteriorated, funding for the programme ceased in 2006.

*ii. Public Assistance Scheme*

The Public Assistance scheme is a social assistance programme that provides assistance in cash or kind to people who are destitute, disabled, elderly, chronically ill and unable to work. It aims to relieve distress and avoid destitution. The Scheme is administered by the Department of Social Welfare. The Scheme has been replaced by the Harmonised Social Cash Transfer Programme (HSCT) which is also a focus of the National Action Plan for Orphans and Vulnerable Children II.

*iii. National Case Management System*

The government of Zimbabwe has responded to the challenges of OVCs with a broad range of policies and programmes on health, education and social assistance. This response is implemented under the National Action Plan for OVCs and coordinated by the recently established National Case Management System. This is a system for coordinating and standardising multi-sectoral responses and interventions for the welfare and protection of children in Zimbabwe. The National Case Management System does this by spelling out the roles, responsibilities and functions of the various stakeholders engaged in this inter-agency collaboration. In addition, it includes the structure of the case management system, standard operating procedures and processes in the case management cycle. The National Case Management System is coordinated by the Department of Child Welfare and Protection Services, which has a statutory mandate for the protection of children in Zimbabwe. Key stakeholders include the Ministry of Health and Child Care, Ministry of Primary and Secondary Education, the National AIDS Council, the Registrar General's Office, Ministry of Justice Legal and Parliamentary Affairs, Zimbabwe Republic Police, traditional leaders and civil society organisations.

The two pillars to the overall response are the Community Childcare Workers (CCWs) and the Child Protection Committees (CPCs). CCWs are “a cadre selected at the community level from village Child Protection Committees to identify vulnerable children in their communities” (Ministry of Public Services, Labour and Social Welfare, 2015: 12). The CCWs provide a link between children and the department of Child Welfare and Protection Services, and play a

critical role in the overall response strategy, as they are involved in every process/stage of the case management cycle from case identification through to case closure. Their responsibilities include: identifying cases, profiling and assessing children and families, keeping records of identified and potential cases, supporting vulnerable children and reporting to the Department of Child Welfare and Protection Services (Ministry of Public Services, Labour and Social Welfare, 2015).

*iv. National Action Plan for Orphans and Vulnerable Children II 2011-2015*

The Ministry of Public Services Labour and Social Services, (now Ministry of Labour and Social Services) formed a National Action Plan (NAP) for Orphans and Vulnerable Children in 2004 in order to increase access to basic services to OVC. NAP provides a national framework for action towards coordinated interventions to support orphans and vulnerable children. Protection, care and support are provided to OVC through education, medical, legal and psychosocial assistance. In 2009, 17,310 child-headed households were assisted with shelter and housing and 16,985 were assisted with livelihood projects (UNGASS, 2010). Between April 2007 and December 2008, the programme assisted 241,664 OVC with various social welfare services (Department of Social Services, 2010 in Mutetwa and Muchacha, 2013).

The framework is in two phases, NAP I 2004 - 2010 and NAP II 2011 - 2015, which is the current phase. NAP II has three pillars/mandates: i) reducing household poverty; ii) improving access to basic education for poor orphans and other vulnerable children iii) enhancing access to child protection services for all vulnerable children. Implementation of these mandates is done through the Harmonised Cash Transfer programme, the Basic Education Assistance Module and Child protection services respectively.

*v. Harmonised Social Cash Transfer Programme*

Cash transfer is one of the main pillars of the NAP II with the aim of reducing household poverty of 55,000 extremely poor households. Drawing from lessons learnt from past cash transfer programmes, the Ministry of Labour and Social Services introduced the Harmonised Social Cash



Transfer (HSCT) Programme for labour constrained<sup>4</sup> households, living below the food poverty line in 2011. Households receive between US\$15 - 25 per month to meet their food and health care needs, although this may not be enough for child-headed households that have to pay school fees. The HSCT functions as a safety net enabling households to become more self-reliant meeting their food and educational needs (Food and Agricultural Organization, 2013).

The programme is administered by the Department of Social Services (DSS), and is financially and technically supported by UNICEF and monitored by the Child Protection Committees (CPCs) at ward level (Schubert, 2010). CPCs assist with informing beneficiaries, monitoring payments and informing DSS of any changes in beneficiaries' status such as deaths. This involvement and leadership of CPCs in the programme, provides strong community participation unlike its predecessor the Public Assistance scheme.

HSCT replaces the Public Assistance programme and aims at harmonising all social protection programmes such as BEAM and Assisted Medical Treatment Orders by ensuring that all beneficiaries are covered by the Treatment Orders and all school aged children in the households receive BEAM assistance (Mtetwa and Muchacha, 2013: 23). The programme recognises that social protection requires a holistic approach incorporating multiple social protection schemes.

vi. *Basic Education Assistance Module (BEAM)*

The Basic Education Assistance Module is a national school fees assistance programme that aims to reduce the number of vulnerable children dropping out and not attending school by providing tuition, levy and examination fees (Mutetwa and Muchacha, 2013). The programme was launched in January 2001 under the Enhanced Social Protection Project (ESPP) and is administered by the Ministry of Labour and Social Services and the Ministry of Education. The programme is now part of the Ministry's National Action Plan for OVC II.

Block grants are given to schools to cover tuition and the levy of vulnerable children who are unable to pay. The block grants system also prevents OVC's being stigmatised, as all poor and needy children are supported by the grant. However, as a result of hyperinflation the block grants

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<sup>4</sup> "Labour constrained means that the household has no member in the working age (19 - 60) who is fit for productive work or that they have a dependency ratio of more than 3" (25)

ceased in 2007 as the contributions devalued before they were even disbursed. In 2009 the programme was resuscitated and 527,310 OVCs were assisted (UNICEF in Masuku *et al.*, 2012). The target of the programme is to reach at least 25% of total primary and secondary enrolment, however, it still does not reach a large number of vulnerable children. The classification/ criteria of vulnerable children is particularly difficult in Zimbabwe, owing to the HIV/AIDS pandemic and socio-economic crisis all children are potentially vulnerable. The programme is once again facing financial challenges as it is no longer supported by the national budget, is donor funded and under the auspices of the NAP for OVC (Masuka *et al.*, 2012).

The programme has its challenges; schools receive the funds late, resulting in children continually being expelled from school. BEAM funds are only paid into the school accounts two school terms later; for example, first term fees are paid towards the end of second term. Each year an annual BEAM Community Selection Committee selects children eligible to be on the programme. However, this selection procedure has received negative attention because of allegations of bias and corruption in the selection of beneficiaries. Another, challenge is that beneficiaries are supposed to be on the programme until they complete their education. However, as a result of the annual selection, some students fail to make it on the following year's selection, not because of the selection criteria but because of budget allocation and increases in school fees. BEAM provides a crucial safety net for vulnerable children.

*vii. Child Protection Services*

Linked to the CCWs are the Child Protection Committees (CPCs) which are a collection of people, often volunteers, who aim to ensure the protection and wellbeing of children in a village, urban neighbourhood or other community (Wessells, 2009). The Ministry of Public Services, Labour and Social Welfare (2015: 12) defines CPCs as “multi-sectoral and multi-stakeholder structures put in place at national and sub-national levels to coordinate implementation of child protection interventions at each level”. (“Committees often comprise of community members, teachers, police and health-workers, who all join and work on a voluntary basis. These Committees exist at village, ward, district, provincial and national levels. The members receive basic training in child protection which encompasses “laws, policies, regulations and services

needed across all social sectors –especially social welfare, education, health, security and justice – to support prevention and protective responses inclusive of family strengthening” (United Nations Economic and Social Council 2008, para 12-13).

The role of CPCs is to identify vulnerable children and the risks confronting them; mobilise and strengthen community based responses for their care, support and protection; ensure that legislation, policy, strategies and programmes are in place to protect the most vulnerable children; ensure their access to essential services and to raise awareness and advocate for the creation of a supportive environment for them. These committees also assist in the selection of beneficiaries for the various social assistance programmes. The committees update the Social Welfare offices of any changes in status of beneficiaries e.g. deaths (Mutetwa and Muchacha, 2013).

*viii. Assisted Medical Treatment Orders*

Initially under the Public Assistance scheme, medical treatment orders have been integrated into the NAP II. Assisted Medical Treatment Orders, are fee waivers issued to vulnerable people to access secondary and tertiary health services i.e. provincial, national hospitals and specialists. The waiver is valid for treatment and subsequent check-ups and valid for 12 months. The health care facilities receive block grants from the Ministry of Labour of Social Services to pay for all the treatment orders.

This scheme has not been very effective as a social protection mechanism, mainly because of the lack of awareness of the existence of the scheme; not many people in Zimbabwe are aware of the treatment orders and of where to access them. Like many of the social security programmes, the scheme has sorely suffered from insufficient government funding.

The department of Social Services provides Assisted Medical Treatment Orders to vulnerable people, which entitles them to free medical treatment. However many child-headed households do not use these because they do not have sufficient information on what they are and where to access them. In Mhondoro, it is particularly difficult to access the Treatment Orders as the Social Services office is in Kadoma, a city that is 60 km away. Rural District Administration offices for

Mhondoro are being set up within the district but this district is quite large and children will still need transport funds to get to the offices.

*ix. Second Chance Education Programme*

In response to the education challenge in Zimbabwe, the Ministry of Education, Sports, Arts and Culture set up the Education Transition Fund (ETF) in 2009, to provide education assistance to out of school children and capacitate the education system. The Fund seeks to reverse the deterioration in the education system that transpired during Zimbabwe's socio-economic downturn. The Education Transition Fund is funded by local and International NGOs such as the Norwegian and German governments and is administered by UNICEF. Under the programme, 22 million textbooks have been distributed to 8,015 primary and secondary schools. In 2011 the second phase of Fund was launched and it is characterised by three thematic areas:

School improvement and system governance; teaching and learning and second chance education for out of school children and youth.

Directly beneficial to child-headed households is the second chance education programme. The programme is a mechanism under the Education Transition Fund and Ministry's Education Mid Term Plan 2011 - 2015, aimed at providing learning opportunities to out of school children and youth (GIZ, *n.d.*). Children enrolled in the programme, are fast tracked through the primary education curriculum in one year, to sit for the grade seven examinations. They are then re-integrated into the formal education system. This gives an opportunity for children, who dropped out, to catch up before being mainstreamed into the formal education system. This programme is currently at the forefront of the policy and practice agenda in Zimbabwe.

The Second chance programme not only addresses the education challenge for these children but also addresses the children's food needs, although in a small and individualistic way. Learners in the *Fit for life* class receive daily meals so as to alleviate hunger, improve nutrition, concentration and attendance. Food shortages in children's homes were affecting the programme

as children failed to concentrate and were often weak and inactive because of hunger. The programme started giving *maheu*,<sup>5</sup> porridge and sometimes tea and bread to the learners.

x. *Zunde raMambo*

Traditionally, rural communities had Zunde raMambo as a food security mechanism. Zunde raMambo is an indigenous food security strategy that acts a contingency for drought, famine and household food insecurity. The practice is at village level, where the chief designates a piece of land that villagers cultivate and the harvest is stored in the chief's granary, as reserve for times of stress (Kaseke, 2006). Zunde raMambo has been in existence for many centuries and in 1980 it was taken up by the Government, which now provides farming inputs such as seed. Ironically, because of economic hardships the initiative had come to an end and was eventually revived in 2010.



xi. *Community Response*

To address children's psychosocial challenges, there is a programme in Mhondoro called *Jekesa pfungwa*<sup>6</sup> that provides psychosocial support to OVC in the form of counselling. In Kadoma, Tsungirirai, a non-profit organisation has quarterly psycho-social camps with OVC providing individual counselling, group counselling and lesson sessions to deal with these psychological issues.

Simbarashe has a School Health Assessment Programme where they work with the Ministry of Health to conduct health assessments on children in schools and refer them to the local clinics. Simbarashe then provides a block grant to the Rural Council for treatment of all the referred children. However, many children from child-headed households do not benefit from this as they are not at school.

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<sup>5</sup> Maheu is a traditional drink made with sorghum, water and sugar

<sup>6</sup> Shona for Enlightenment

## 4.4 Discussion

The situation analysis has shown that child-headed households in Zimbabwe form as a result of: migration of parents, failure of the extended family to absorb children because of poverty as well as weak kinship ties. Structural factors such as economic failure, influence the establishment of these households, since poverty at household level, weakens the extended family safety net. As evidenced in other studies (Ntozi *et al.*, 1995; Foster *et al.*, 1997; Foster and Williamson 2000; Makame *et al.*, 2002; Germann, 2005a; Dalen, 2009), relatives are not able to support and take in orphans, as they are struggling themselves.

Perceived challenges of children living in these households range from poor physical health to food insecurity. However, child-headed households formed as a result of parents migrating are unique to other child-headed households, as they are well supported, receiving remittances from their parents, and are therefore less likely to experience challenges such as food insecurity, dropping out of school and material deprivation.

In response to the challenges of children in child-headed households and other vulnerable children, the country has adopted a multi-sectoral approach, targeting all areas of vulnerability which include education, health, food security and protection from all forms of abuse. The Child Protection Services programme in particular, applies this multi-sectoral approach. Tanzania has a similar programme, the “most vulnerable child” programme that has committees operating at ward and village levels. Social protection interventions for vulnerable children in Zimbabwe have evolved in their approach as well as the legal framework. The challenge however, is that they are pillared on the CCW cadre who are volunteers, making the interventions fairly fragile in terms of capacity and sustainability. The high expectation without remuneration placed upon these CCWs is concerning.

The current context of severe economic decline, hyperinflationary conditions and humanitarian crises has substantially complicated the nation’s ability to provide social protection to vulnerable populations. Poor economic performance has resulted in reduced government spending and massive budget cuts in social welfare; and consequently, many programmes were discontinued. Financial resources available to implement social protection programmes, diminished (Schubert, 2010). Of note is the value of BEAM resources was wiped out and the funding drastically

reduced in 2008. As a result, there has been increasing inconsistencies in implementation, as interventions are operating intermittently. A programme intended to be nationwide is not implemented in other provinces and in other instances the programme ends, after four months in operation because of funding constraints.

### *Macro-economic Challenges Affecting Social Protection*

It is important to contextualise this study and recognise that child-headed households are situated within a broader economic and political landscape. The challenges that child-headed households experienced in this study were exacerbated by deepening poverty, incessant political instability, recurrent droughts and nationwide food insecurity in Zimbabwe. This also inhibited children's agency and influenced the coping strategies they adopted. Findings from this study therefore may not be comparable to more stable/less volatile countries such as South Africa.

From the findings, it is evident that macro-economic stagnation in the country has greatly impeded the State's ability to provide adequate social protection to vulnerable children, particularly child-headed households. Social systems in Zimbabwe are severely compromised. Interventions are implemented unevenly and erratically in "stop-start" intervals based on funding availability. CCWs, the cadre at the centre of the new National Case Management System are not remunerated. Furthermore, the State departments lack proper information management systems, a critical element in monitoring and sustaining social protection efforts. Practitioners and implementers should recognise this contextual reality when planning interventions (UNICEF, 2009).

In addition to economic failure, social protection interventions for child-headed households and OVCs in general have been plagued by the impediment of corruption and politicisation of programmes. In particular, the BEAM programme where the selection of beneficiaries is no longer transparent, with recipients being largely prominent members of society and the most vulnerable being excluded.

Another confounding factor is accessibility of Social welfare and Social services offices; this has hampered the utilisation of many of the mechanisms and has been a barrier to children most in need of the services, for example the Social services office for Mhondoro. The rural study site



was in the district town over 60 km away, and children would need public transport to get there. CPCs now play an important role to improve accessibility as selection processes for most schemes under the NAP are at community level.

## **4.5 Summary**

This chapter presented findings of the situation analysis of child-headed households in Zimbabwe. Child-headed households are formed as a result of weak kinships in rural communities, poverty and children choosing to live alone. Organic rural communities, where kinship ties are stronger, have fewer child-headed households compared to rural communities with a mélange of clans with no kinship ties, such as settlements established under the Fast Track Land Reform Programme. Perceived challenges of child-headed households were poor health, psychological distress, financial insecurity, failure to access healthcare services, failure to obtain birth certificates, vulnerability to abuse, lack of adult support and dropping out of school. Stakeholders also indicated that child-headed households are supported by relatives and community members, however, poverty and economic instability in Zimbabwe has reduced their ability to support these orphans. Zimbabwe has a range of social protection mechanisms for orphans and vulnerable children, which also cater for those living in child-headed headed households. However, economic and political instability in Zimbabwe has immobilised these programmes. These findings provided an overview of the situation of child-headed households in Zimbabwe, informing the survey and ethnographic phases of the study.

## **CHAPTER 5**

### **CROSS-SECTIONAL SURVEY OF QUALITY OF LIFE OF ORPHANS LIVING IN CHILD-HEADED HOUSEHOLDS**

#### **5.1 Introduction**

The situation analysis provided insight on the context and perceived challenges of child-headed households in Zimbabwe. The situation analysis revealed that Zimbabwe is currently a ‘fragile state’ with weak and in some cases dysfunctional social systems, in particular health, education, housing, food security and social protection. Secondly, findings indicated that orphans from child-headed households experience psychological distress, poverty and material lack. A descriptive cross-sectional survey was conducted to explore and quantify these perceptions and to explore whether the context of the fragile state affected quality of life in child-headed households.

This chapter discusses findings from the survey. The methods used to conduct the survey are discussed in detail and results are presented thematically, according to the five WHO quality of life domains. This is followed by a discussion of the findings and their implications for children living in child-headed households.

#### **5.2 Methodology**

The aim of the current research phase was to describe self-perceptions of quality of life amongst orphans living in child-headed households in low-income rural and urban settings in Zimbabwe. A descriptive cross-sectional survey design was employed, in order to obtain a snapshot of the quality of life in child-headed households between June and August 2016. A descriptive cross-

sectional survey provides information about a defined population at one specific point in time (Creswell, 2012). Driscoll *et al.* (2007) point out that beginning with the quantitative phase, in sequential mixed methods studies helps determine which data to augment and follow up in the next phase. Similarly, in this study, the survey served to identify issues that could be explored in the qualitative inquiry. Furthermore, using a descriptive survey design enabled the simultaneous assessment of multiple quality of life variables.

### **5.2.1 Description of Study Settings**

The survey was conducted in 3 settings: Harare, Chegutu urban and Chegutu rural. Harare is the capital city of Zimbabwe and the largest metropole in the country. Being the capital city, Harare is economically vibrant, specialising in service provision (Parliament of Zimbabwe, 2011), ranging from financial, transport (international, bulk), communication and commercial retail services. Harare is also the major hub of manufacturing companies.

Chegutu is an agricultural area and formerly a mining town, situated 103 km south-west of Harare and is the district town for Chegutu district in Mashonaland West Province. The main economic activities for the district are mining and agricultural activities. A detailed description of the areas is presented in chapter 6 to contextualise the qualitative findings.

Chegutu rural district is composed of a combination of commercial agricultural farms and communal rural settlements.

### **5.2.2 Study Population and Sampling**

The study population consisted of single and double orphans, who were above seven years of age and lived in unaccompanied child-headed households. Unaccompanied child-headed households are households, where all resident members are children with no resident adult (Foster *et al.*, 1997). Participants, who were 18 – 23 year olds, were also included in the study if they had previously been heading child-headed households, which became adolescent-headed households as the household heads grew older. These older household heads were a potential source of rich data on the experiences of child-headed households, as some of them have been heading child-headed

households for as long as nine years. Furthermore, the situation analysis revealed that these households were considered as child-headed households by many communities.

Lists of children and adolescents living in child-headed households were obtained from Child Care Workers (CCWs) in the three study sites and the total was 116 children and adolescents. Inclusive sampling technique was applied and the entire study population was sampled. Eleven questionnaires were discarded because of sampling error and nine were discarded because of data entry errors. Two additional households were obtained through snowball sampling as participants referred us to other children living in child-headed households. The total number of children and adolescents that participated in the study was 96.

### **5.2.3 Data Collection**

#### *Survey Instrument*

The WHOQOL-BY instrument was employed in the survey, this tool originates from the WHOQOL-100 and the WHOQOL-BREF. There are two original WHOQOL psychometric assessment tools, the WHOQOL-100 and the WHOQOL-BREF. These are self-administered psychometric assessment tools developed by the World Health Organisation for assessing an individual's quality of life. The WHOQOL-100 is the original instrument which consists of 100 questions and six domains: physical health; psychological; level of independence; social relationships; environment; spirituality, religion and personal beliefs. The WHOQOL-BREF is an abbreviated version of the WHOQOL-100 designed for use in larger studies and in contexts where the longer questionnaire is not practical (WHOQOL Group, 2012). It consists of only 26 questions and four domains as the physical health and level of independence domains as well as the psychological and the spirituality, religion and personal beliefs domains were merged. Responses are based on a 5 point Likert scale ranging from very dissatisfied (1) to very satisfied (5).

These two instruments have been, and continue to be adjusted for measuring quality of life of different population groups. The WHOQOL-BREF was adjusted to form the WHOQOL-BY for use with youths and was used by Germann (2005a), to measure the quality of life of children living in child-headed households in Zimbabwe. It was on this basis that this study employed the

WHOQOL-BY, as it was developed specifically for youths and had already been used on the same population group in the same context, which is children living in child-headed households in Zimbabwe.

Similar to the WHOQOL-BREF, the WHOQOL-BY consists of four domains and 26 questions. The physical health domain, explores the extent individuals experience physical pain and discomfort that are distressing and interfere with their life, affecting their energy, sleep and mobility. Questions on mobility and ability, to do daily activities, also refer to an individual's level of independence. Pain refers to unpleasant physical sensations such as stiffness, aches and itches (WHOQOL, 1992). The psychological domain explores how individuals feel about themselves and their life, as well as the extent they experience negative feelings and whether their concentration is affected. The third domain is social relationships, exploring the extent that individuals feel they receive the support they desire from relationships in their lives, as well as their satisfaction with the companionship and practical support from family and friends. The environment domain is broad and examines various facets of an individual's life which include safety, satisfaction with physical and living environment, financial wellbeing as well as access to information, services and transport.

Permission to use the WHOQOL-BY tool was obtained from the WHOQOL centre in Geneva, Switzerland. Using the Shona version (the indigenous language in Zimbabwe), the WHOQOL-BY was pre-tested on 12 orphans from child-headed households, not part of the sample population. The purpose of the pre-test was to establish the time required to administer the instrument and assure understanding of the instrument by respondents across the age groups. Feedback from the pre-test provided useful information and the final WHOQOL-BY was adjusted by removing the question on sex life.

#### *Data Collection Process*

After pretesting and adjustment, the WHOQOL-BY was administered to the study respondents; children were asked to respond to the questions on the tool and for children with reduced ability to read and write, the interviewer assisted by reading out the questionnaire as per the WHOQOL manual instructions.

Fieldwork also included negotiating access and seeking permission from the Ward Counsellors and Social Welfare offices for each site; this process took two days for each site. The survey was conducted in 4 weeks. In the Harare and Chegutu rural sites, the survey took longer, owing to the large distances between settlements and the households.

A research assistant was hired to assist the researcher with the survey. The research assistant had prior experience in community engagement and primary data collection. Before initiating fieldwork, the assistant received training on the aim, objectives and structure of the study; a background of the study population; all data collection tools and procedures; research ethics, data entry as well as data analysis procedures.

#### **5.2.4 Data Management and Analysis**

##### *Data Entry, Cleaning and Quality Checks*

At the end of each fieldwork day, data was manually entered into an excel spreadsheet by the researcher. An SPSS syntax file that checks, recodes and computes domain scores, obtained from the WHOQOL centre, was used in the cleaning and initial analysis of data. All negatively framed questions were reversed into positive responses using the formula provided in the syntax file.

Data cleaning was performed by examining the data for missing values using frequency distributions. Scatter plots were used to identify outliers. Missing data such as age and sex were corrected by going back into the field and tracing respondents. A total of 18 variables had missing values. Missing values were substituted with the mean of the variables within the domain of the missing value.

##### *Analysis*

Data was transferred to SPSS version 23 and descriptive analysis was conducted; this included frequency distribution, measures of central tendency and variability for all items. Correlations between domains and cross-tabulations of variables by location and gender were performed. Only descriptive statistics were conducted, because the objective was to describe the physical health, psychological wellbeing as well as satisfaction with social relationships and

environmental factors of children and adolescents living in child-headed households thereby identifying factors for exploration in the qualitative phase.

Using the WHOQOL-BREF manual, domain raw and transformed scores were manually calculated in Excel. The domain raw scores were calculated by multiplying the domain mean score by four. Domain scores are multiplied by four so that they are directly comparable to WHOQOL-100 scores (WHO, 2012). Domain scores are scaled in a positive direction, higher scores denote higher quality of life thus scores above 50% are regarded as good wellbeing (WHOQOL Group, 2012). Transformed scores were calculated by multiplying the domain scores by 100 over 16. Compounded responses were calculated by adding all the positive responses and negative responses for each domain providing an overview of each domain.

## **5.3 Results**

### **5.3.1 Socio-demographic Characteristics of Study Sample**

Out of 96 respondents, 50 were male and 42 were female. Harare had 59 respondents, Chegutu urban had 6 and Chegutu rural had 31 respondents. The age range was 6 – 23 years, as mentioned earlier, the study included youths up to the age of 23 years. With regard to education levels, 10% (10) of the respondents had no education or were not yet in school at the time of the survey, while 51% (49) only had primary education and 39% (37) had secondary education.



**Table 5.1: Socio-demographic characteristics of study participants (N= 96)**

Characteristics	Harare (n = 59)	Chegutu urban (n = 6)	Chegutu rural (n=32)	Total (n=96)
<b>Sex</b>				
Male	29 (49)	3 (50)	22 (71)	54 (56)
Female	28 (48)	3(50)	9 (29)	40 (42)
Not indicated	2(3)			2 (2)
<b>Age (in years)</b>				
5-9	8 (14)	0	3 (10)	11 (12)
10-14	22 (37)	0	7 (23)	29 (30)
15-17	23 (39)	0	5 (16)	28 (29)
18-21	6 (10)	6 (100)	16 (51)	28 (29)
<b>Education:</b>				
No education	3 (5)	0	7 (23)	10 (10)
Primary	34 (58)	0	15 (48)	49 (51)
Secondary	22 (37)	6 (100)	9 (29)	37 (39)

### 5.3.2 Quality of Life Domains

Scores from the psychological, physical, social relationships, environment and general quality of life domains in the psychometric questionnaire are presented in turn.

#### *Psychological Domain*

Figure 5.1 illustrates that the majority (63%) of the respondents indicated that they enjoyed life; 31%, 28% and 4% reported that they enjoyed life *moderately*, *very much* and *an extreme amount* respectively. The remaining 37% indicated that they did not enjoy life; 25% and 12% reported that they enjoyed life *a little* and *not at all* respectively. The majority of the respondents (65%) also felt that their life was meaningful; 29%, 28% and 8% reported that they felt their life was meaningful *a moderate amount*, *very much* and *an extreme amount*.

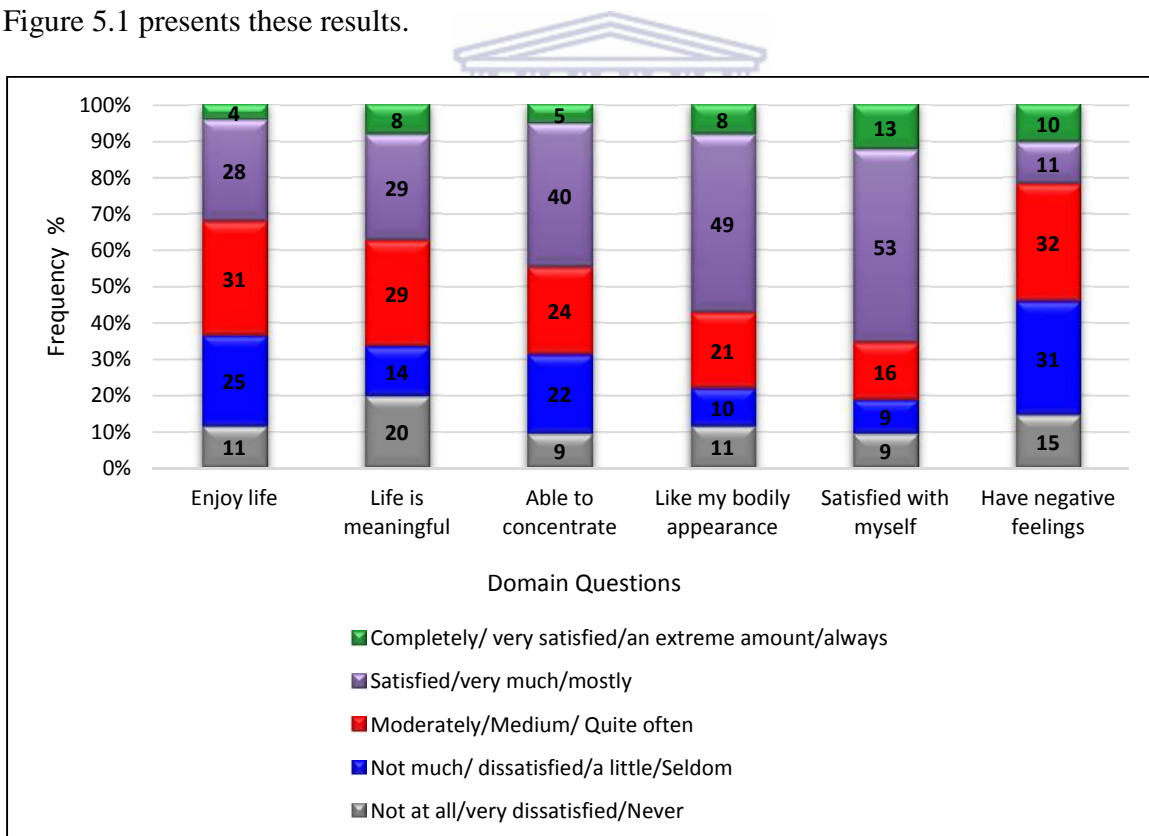
More participants in urban areas (71%) found life to be meaningful compared to those in rural areas where only 58% indicated they found life to be meaningful (see figure 5.2).

Most respondents reported being able to concentrate in their daily activities as 24%, 40% and 5% reported being able to concentrate *a moderate amount*, *very much* and *an extreme amount*

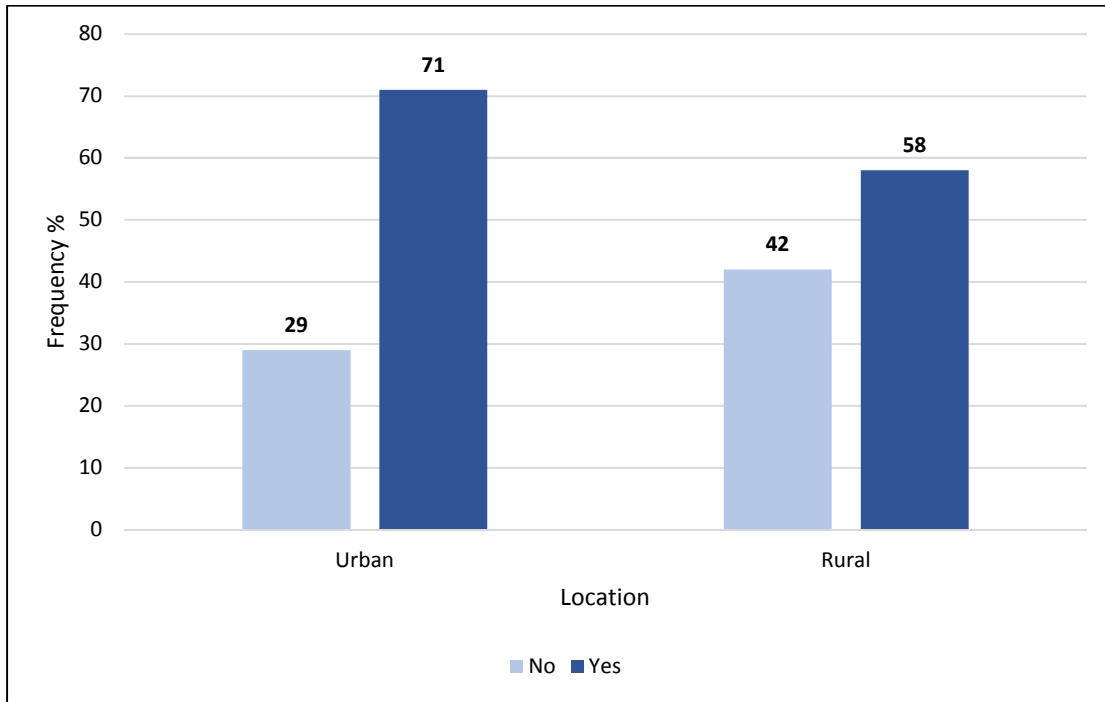
respectively. A small number however, reported that they were not able to concentrate well; 22% and 9% indicated that they were only able to concentrate *a little* and *not at all* respectively.

Most respondents (77%) indicated that they accepted their bodily appearance; 20%, 49% and 8% reported that they accepted their bodily appearances *moderately*, *mostly* and *completely* respectively. Similarly, majority (82%) reported being satisfied with themselves; 16%, 53% and 13% reported being *medium*, *satisfied* and *very satisfied* with themselves respectively. Surprisingly, more females (82.5%) were satisfied with themselves than males (80%) (see figure 5.3).

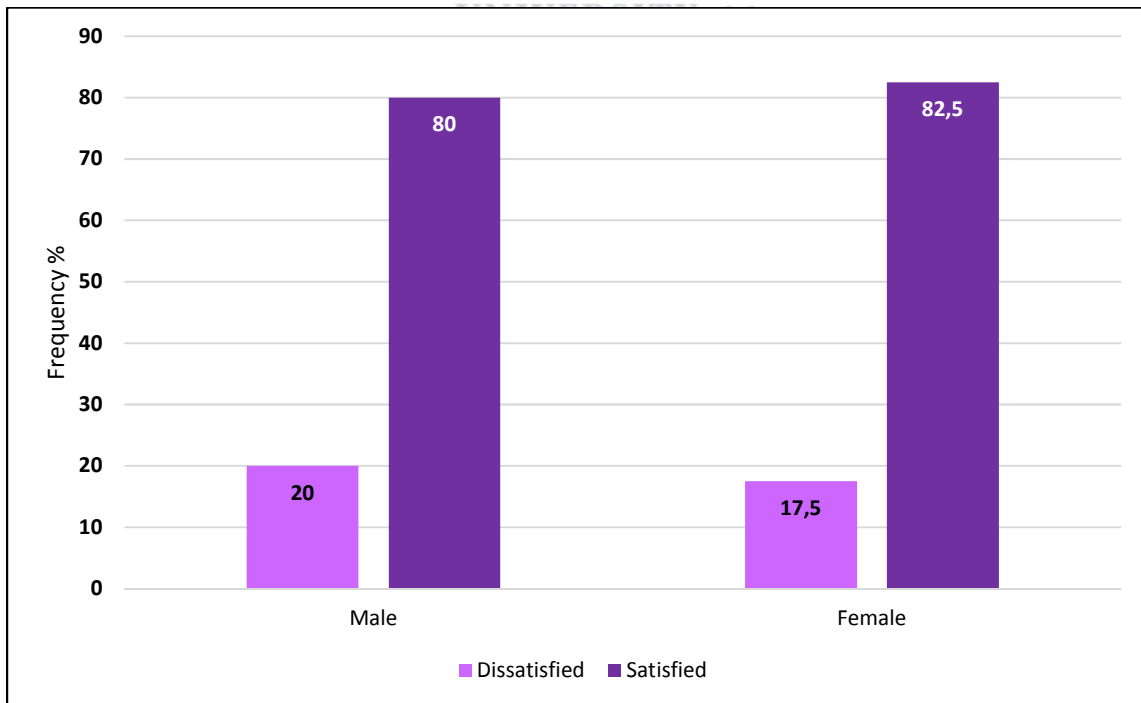
More than half (53%) of the respondents reported that they experienced psychological distress in the form of depression, anxiety or despair; 11% and 10% reported that they had these experiences *always* and *mostly*, respectively, while 32% had these experiences *quite often*. Figure 5.1 presents these results.



**Figure 5.1 Psychological domain responses (n = 96)**



**Figure 5.2 Life is meaningful responses by location (n = 96)**



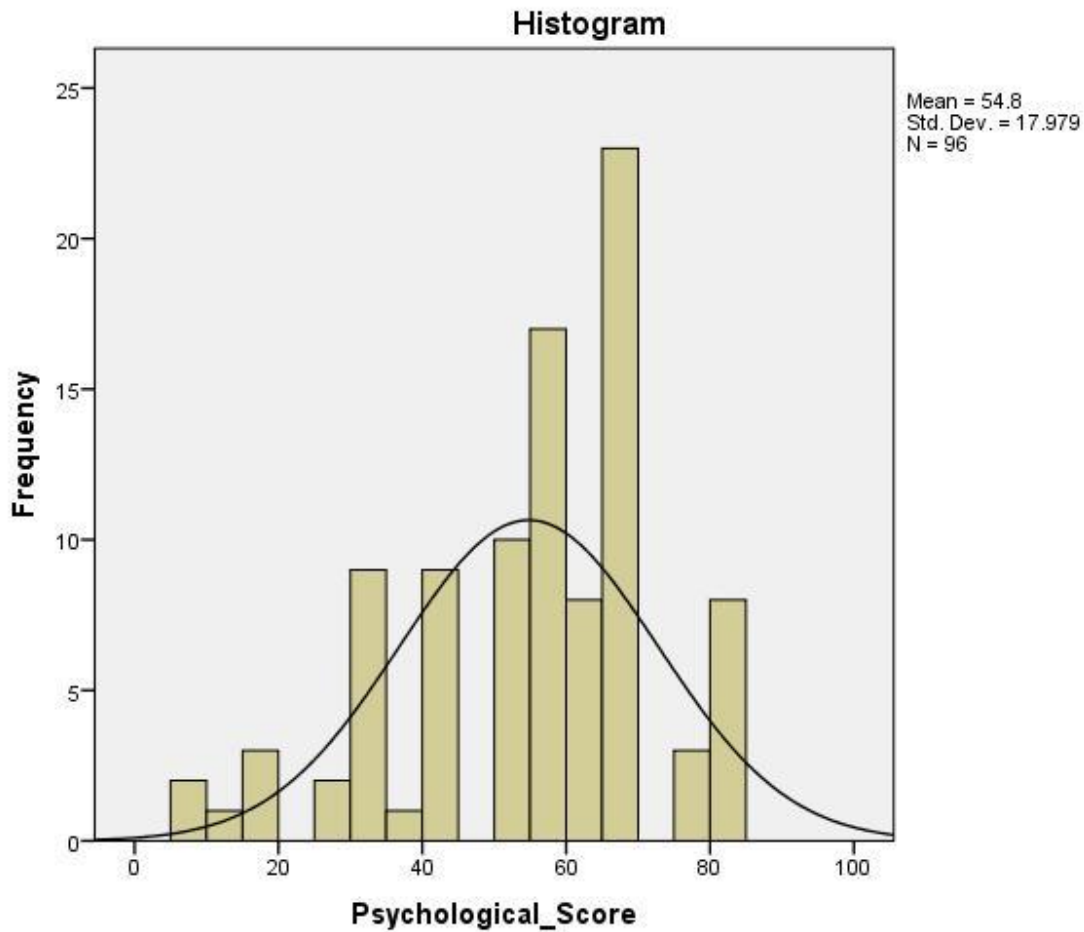
**Figure 5.3 “Satisfaction with self” responses by sex (n = 96)**

Overall, the majority of the participants scored relatively high in the composite domain score as indicated in table 5.2. Scores are positively scaled; meaning that the higher the score, the higher the psychological wellbeing of respondents. The majority (51%) scored between 51 - 75 % giving a median score of 56% with a standard deviation of 17.979. A few (38.5%) respondents scored below 50% which is the average score. This indicates that psychologically, most respondents are doing well, although there is concern for those scoring below 25%. Figure 5.4 shows the histogram of the psychological domain scores. The scores produce a close to normal curve with mild negative skewness (-.732).

**Table 5.2: Psychological domain composite scores**

<b>Domain scores %</b>	<b>Frequency n (%)</b>
0-25	8 (8.3)
26-50	29 (30.2)
51-75	51 (53.1)
76-100	8 (8.3)





**Figure 5.4 Histogram of psychological domain scores**

### *Physical Domain*

The physical health domain assessed respondents' perception of their physical health, mobility and level of independence. There was a positive response in the physical domain as most respondents scored above 50% in the overall composite domain scores. Figure 5.5 presents responses from domain questions.

The majority (64%) reported not being affected by physical pain; 16% and 48% reported that physical pain affected them *not much* and *not at all* respectively. It is however, worrying that up to 37% reported that they experienced some type of physical pain which affected their ability to

carry out their daily activities; 15%, 19% and 3% reported experiencing this physical pain *moderately*, *very much* and *an extreme amount* respectively. In addition, 34% reported that they need medical attention to function daily; 18%, 12% and 4% need this medical attention *moderately*, *very much* and *an extreme amount* respectively. Furthermore, many respondents (20%) scored below 50% in the overall composite domain score indicating poor physical health.

The majority (73%) had enough energy for everyday life; 23%, 40% and 10% reported having energy for everyday life *moderately*, *mostly* and *completely* respectively. Similarly, most respondents (83%) reported being satisfied with their sleep; 20%, 51% and 12% reported *medium*, *satisfied* and *very satisfied* respectively. This energy is evidenced in children's satisfaction with their ability to perform daily activities and to work as 81% were satisfied with their ability to perform daily activities; 20%, 47% and 14% reported *medium*, *satisfied* and *very satisfied* respectively.

Similarly, the majority (84%) were satisfied with their capacity for work; 20%, 51% and 13% were *moderately*, *satisfied* and *very satisfied* with their capacity for work. This leaves 19% and 16% dissatisfied with their ability to do daily activities and capacity for work respectively; this tallies with 37% reporting being affected by physical pain and 15% needing medical attention and medicine to function daily indicating that children's poor physical health hinders their ability to perform.

In terms of mobility, only 57% indicated they were able to get around well; 48% and 9% indicated that their ability to get around was *good* and *very good* respectively. Mobility in this context refers to a person's ability to get from one place to the other regardless of the means used, reflecting an individual's level of independence. Surprisingly, as many as 43% reported that they were not able to get around; 17%, 13% and 13% reported that their mobility was *neither good nor bad*, *poor* and *very poor* respectively. More participants residing in rural areas (61%) indicated they were able to get around compared to participants in urban areas (55%) as shown in figure 5.6.

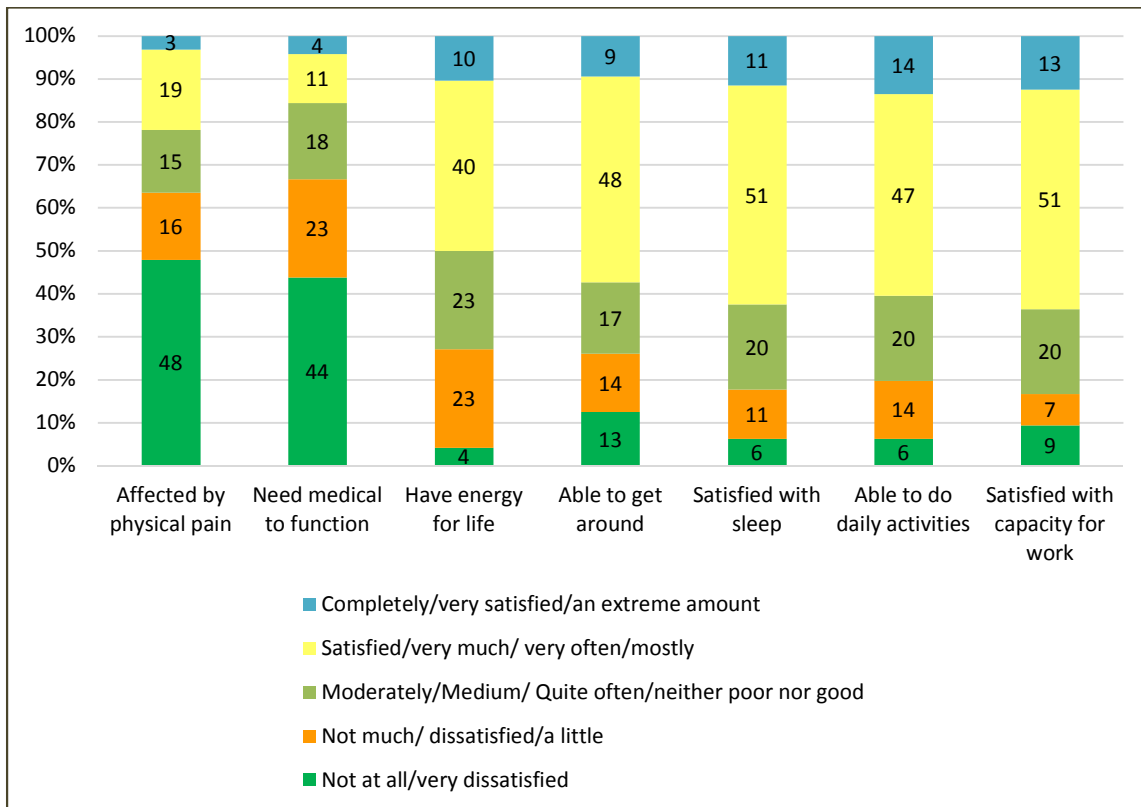


Figure 5.5 Physical domain responses (n = 96)

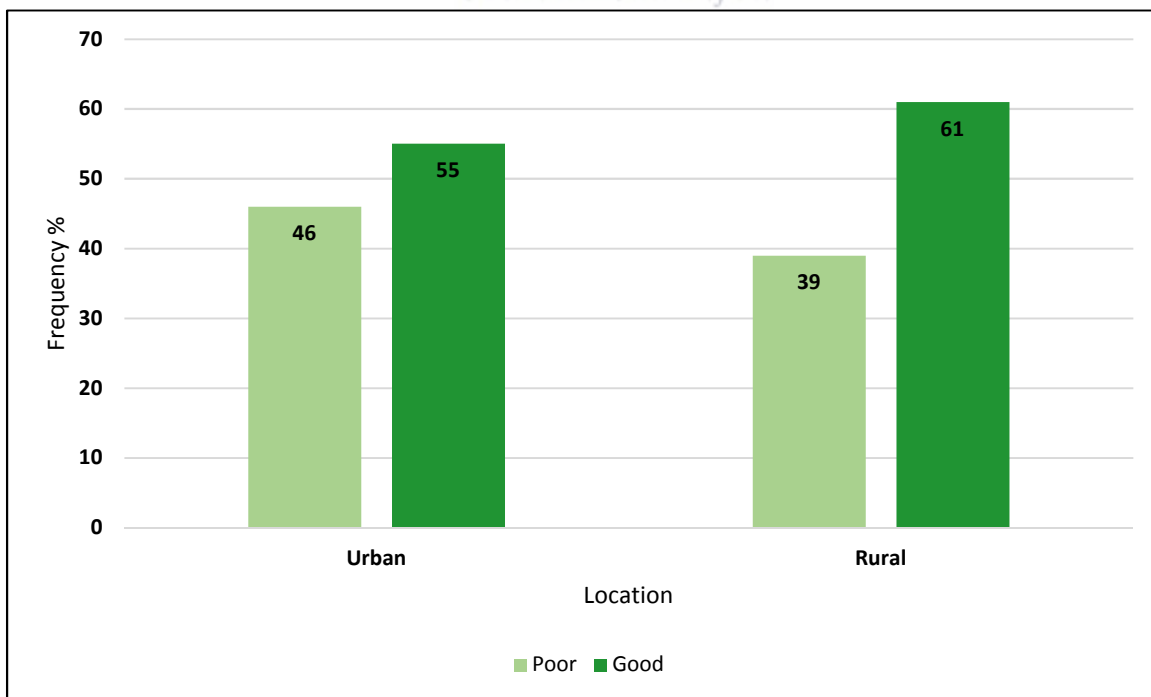


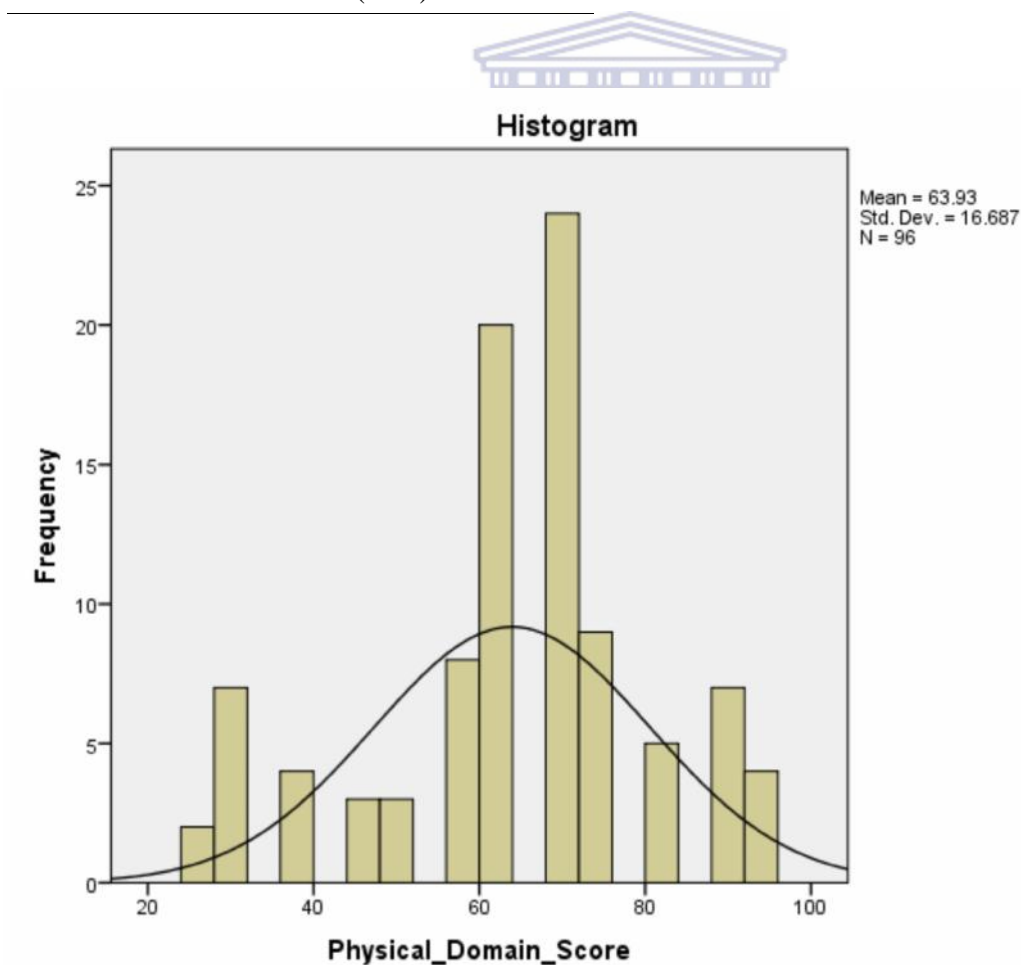
Figure 5.6 Mobility by location (n = 96)



Table 5.3 presents the composite scores for the physical domain. Of all 5 domains, the physical health domain had the highest scores with a median score of 69% and a standard deviation of 16.687. Majority (80%) of the participants scored above 50% indicating that the majority were satisfied with their physical health and felt that they were healthy. Figure 5.7 presents a histogram of these scores, the scores show a near normal curve with a mild negative skewness (-.525).

**Table 5.3: Physical domain composite scores**

Domain scores %	Frequency n (%)
0-25	2 (2.1)
26-50	17 (17.7)
51-75	61 (63.5)
76-100	16 (16.7)



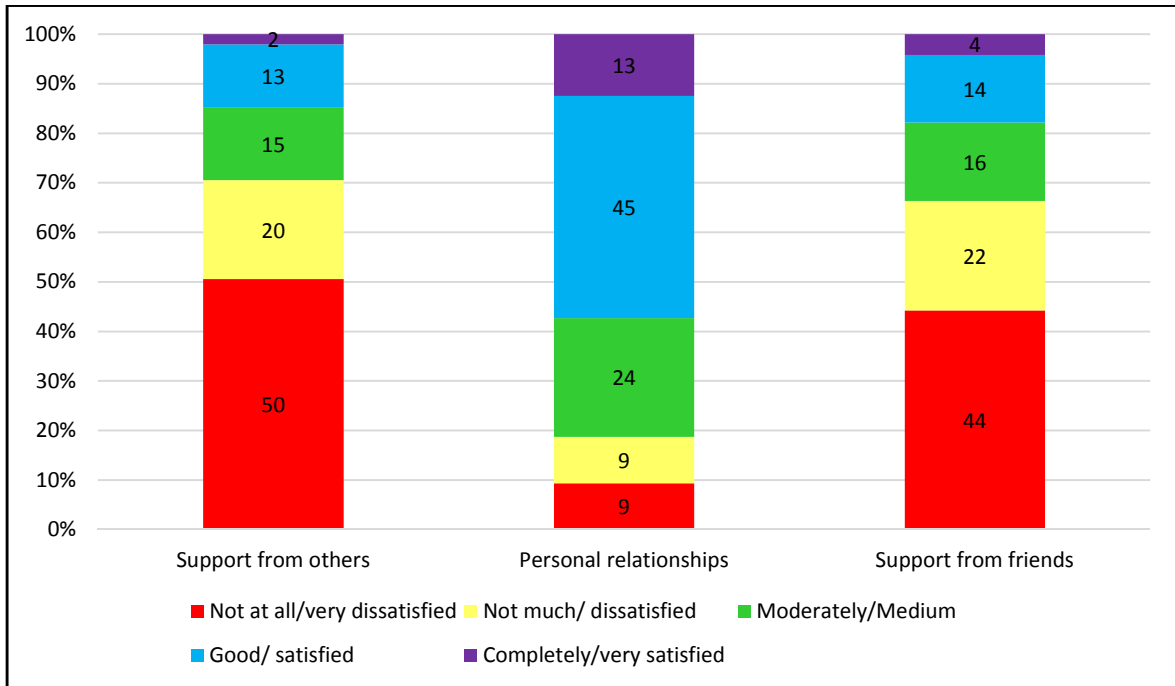
**Figure 5.7 Histogram of physical domain scores**

### *Social Relationships Domain*

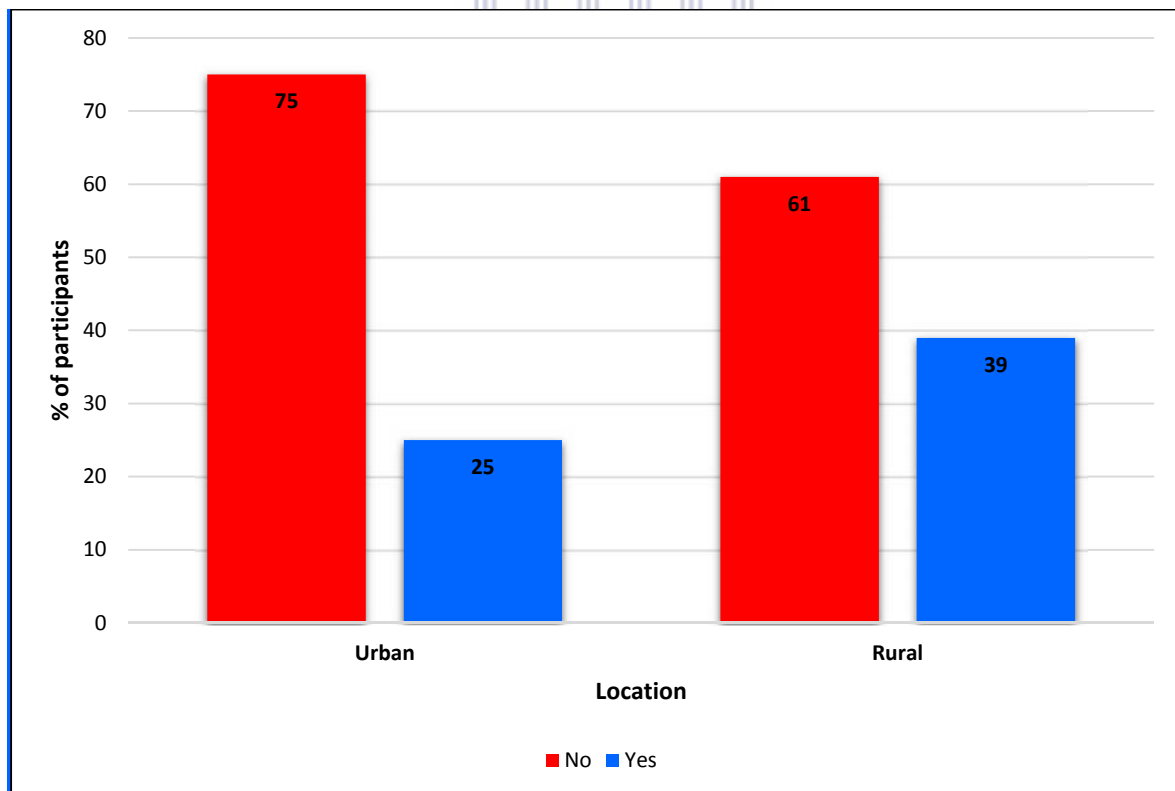
The social relationships domain explores individuals' satisfaction with their personal relationships, support from friends and support from others. The majority (70%) of the respondents reported that they did not receive the kind of support they needed from others; 20% and 50% reported that they received *not much* support from others and *not at all* respectively (see figure 5.8). More participants in urban areas (75%) indicated that they did not receive the support they needed from others compared to those in rural areas (61%) as shown in figure 5.9.

Similarly, respondents also reported that they did not receive the support they needed from friends; 22% and 44% reported being *dissatisfied* and *very dissatisfied* with the support they received from friends. However, in sharp contrast, 82% were satisfied with their personal relationships; 24%, 45% and 13% reported being *medium*, *satisfied* and *very satisfied* with their personal relationships respectively. Social support proved to be essential to children's psychological wellbeing and quality of life as there was a moderate relationship (correlation of .466) between social support and psychological wellbeing.

Correspondingly, participants' dissatisfaction with their relationships and support is reflected in the overall domain scores as majority (80%) of the participants scored below 50% while only a few (17%) scored between 51 - 75% and very few (3%) scored higher than 76% as presented in table 4 below. These results indicate that respondents performed poorly in this domain as majority was below 50%. A histogram of these scores is presented in figure 5.10 showing a close to normal curve with mild positive skewness (.516).



**Figure 5.8 Social relationships domain responses (n = 96)**



**Figure 5.9 Satisfaction with support from others in urban and rural areas (n = 96)**

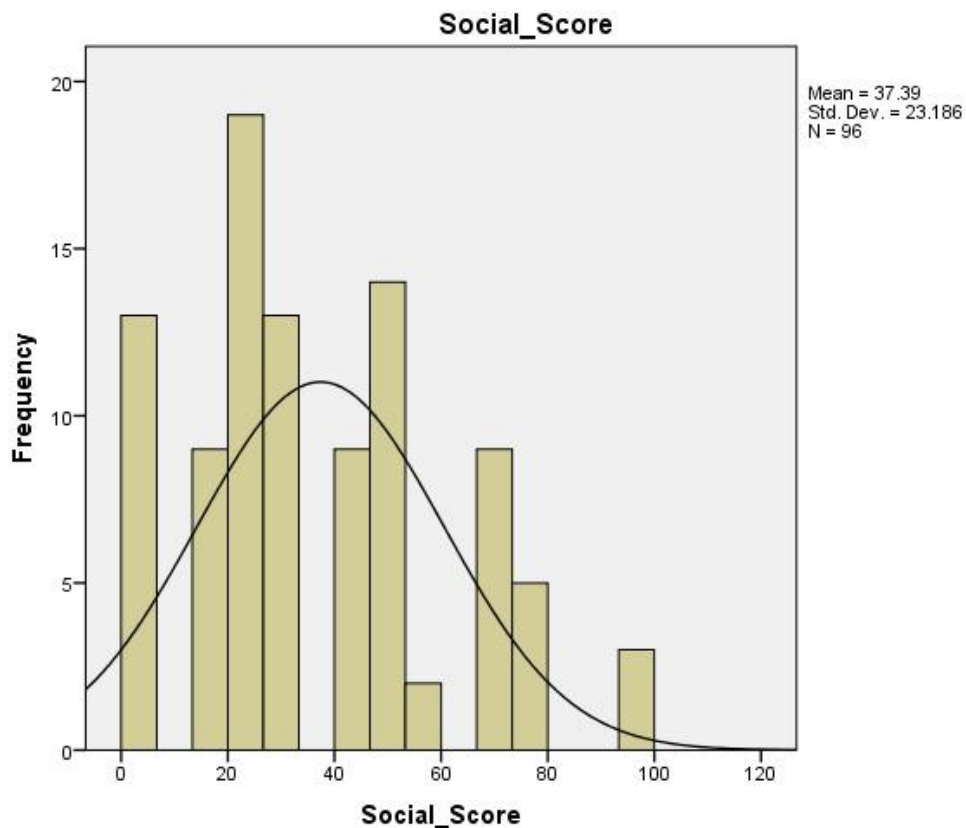


Figure 5.10 Histogram of social domain scores

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Table 5.4 Social domain composite scores

Domain score %	Frequency n (%)
0-25	41 (42.7)
26-50	36 (37.5)
51-75	16 (16.7)
76-100	3 (3.1)

#### *Environment Domain*

In this section of the questionnaire participants responded to questions relating to physical and living environment, financial wellbeing and opportunity for leisure. Findings are presented in figure 5.11.

The majority (67%) of the respondents indicated that they felt safe; 17%, 46% and 4% reported that they felt safe *moderately*, *very much* and *an extreme amount* respectively. A few (17%) respondents also reported that they did not feel safe at all. Correlations indicate that there is a weak relationship (correlation of .299) between safety and location, however, figure 5.12 shows that children living in the rural areas reported feeling safer as compared to those living in the urban areas. In addition, more males (76%) felt safe in their homes and community than girls (52.5%) as shown in figure 5.13.

The majority (64%) reported being satisfied with their physical environment in terms of pollution and aesthetics; 19%, 41% and 4% reported *moderately*, *satisfied* and *very satisfied* with their physical environment respectively. A significantly higher number of participants in rural areas (81%) were satisfied with their physical environment compared to participants in urban areas (55%) (see figure 5.14).

Participants showed greater dissatisfaction with their living (home) environment in terms of overcrowding, cleanliness and infrastructure of the home. In comparison to satisfaction with the physical environment, fewer (54%) respondents were satisfied; 28%, 25% and 1% reported *medium*, *satisfied* and *very satisfied* respectively. A considerable number (46%) of respondents reported not being satisfied with their living environment; 24% and 22% were *dissatisfied* and *very dissatisfied* with their living environment respectively. In urban areas, more participants (58%) were dissatisfied with their living environment, while in urban areas more participants (81%) were satisfied with their living environment.

Most respondents (93%) expressed that they did not have enough money to meet their needs; 24% and 69% reported that they had *a little* money and *not at all* respectively. Few respondents (5%) indicated that they had *a moderate amount* of money and very few (2%) *mostly* had enough money to meet their needs. No respondents indicated that they completely had enough money.

The majority (70%) indicated they did not have much information of what is going on in their surroundings; 40% and 30% reported having *little* information and *not at all* respectively. A few respondents (19%) reported they had *a moderate amount* of information. Very few respondents, 2% and 9% indicated that they *completely* and *mostly* had information respectively.

Only a few respondents (48%) indicated that they had considerable time for leisure activities; 28%, 14% and 6% reported having time for leisure activities *moderately*, *mostly* and *completely* respectively. Some respondents (22%) indicated that they had *little time* (22%) and others while others reported *not at all* (28%).

The majority (65%) were satisfied with their access to health services; 30%, 27% and 8% reported being *moderately satisfied*, *satisfied* and *very satisfied* respectively. This question reviewed the availability and accessibility of health services to children living in child-headed households. This implies that children can access a clinic or hospital should they need one. However, a significant number (34%) of respondents were not satisfied with access to health services; 24% and 10% reported being *dissatisfied* and *very dissatisfied* respectively. There was no association (correlation of .125) between access to health care and location, meaning location was not a significant factor in health care access. Although, more participants in rural areas indicated satisfaction with access to health services as shown in figure 5.16.

Similarly, many (66%) respondents reported being satisfied with access to transport; 18%, 35% and 13% reported being *moderately satisfied*, *satisfied* and *very satisfied* respectively. However, respondents also reported being *dissatisfied* (16%) and *very dissatisfied* (19%) with their transport situation. As expected, a higher percentage of participants in urban areas (74%) reported being satisfied with transport than participants in rural areas (48%) as presented in figure 5.17.

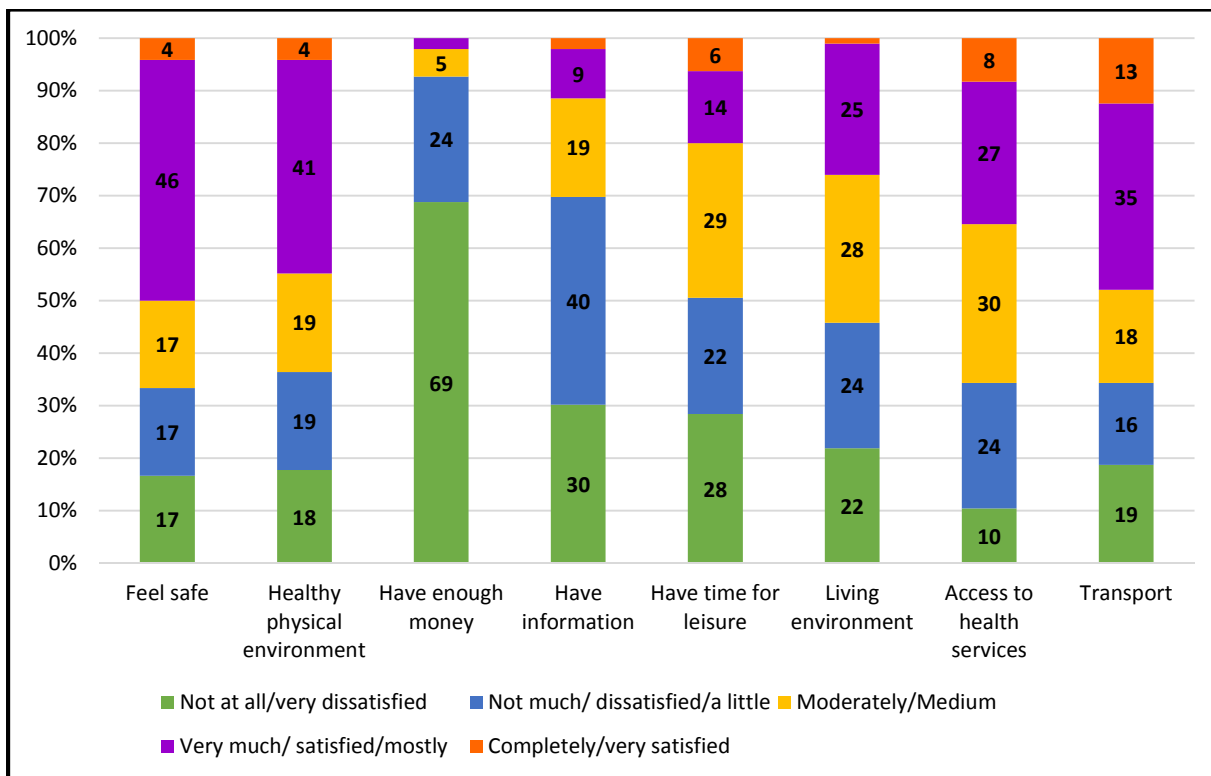


Figure 5.11 Environment domain responses (n = 96)

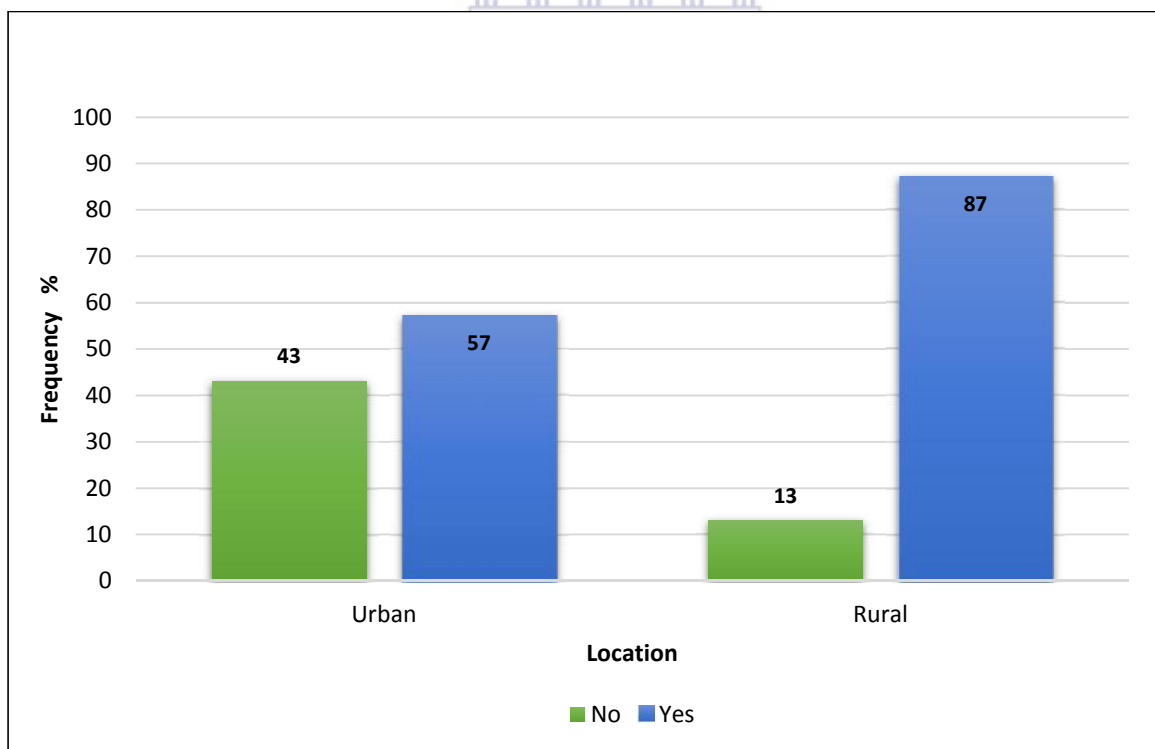


Figure 5.12 Safety responses in urban and rural areas (n = 96)

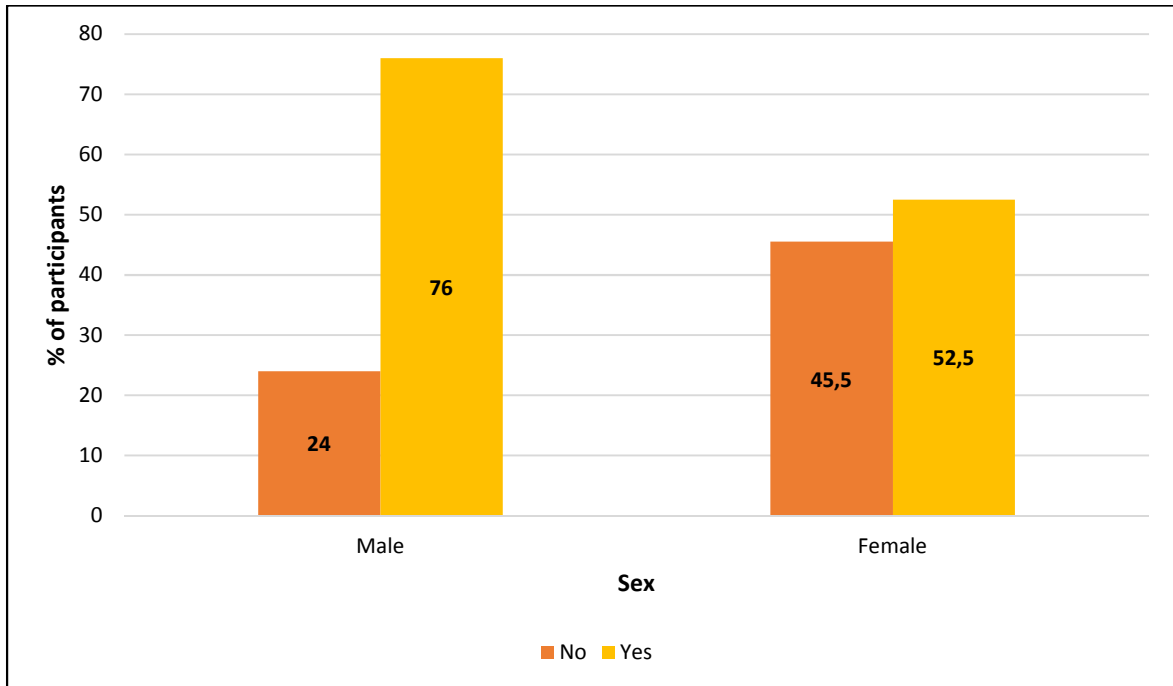


Figure 5.13 Feelings of safety amongst males and females (n = 96)

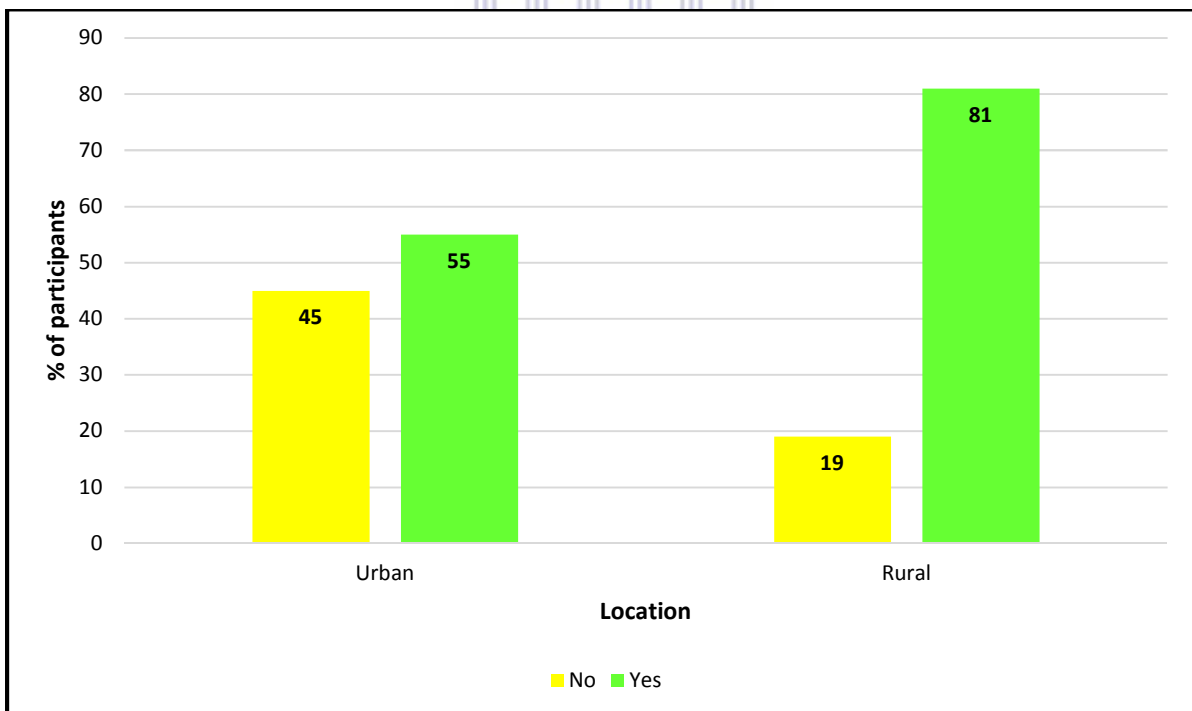
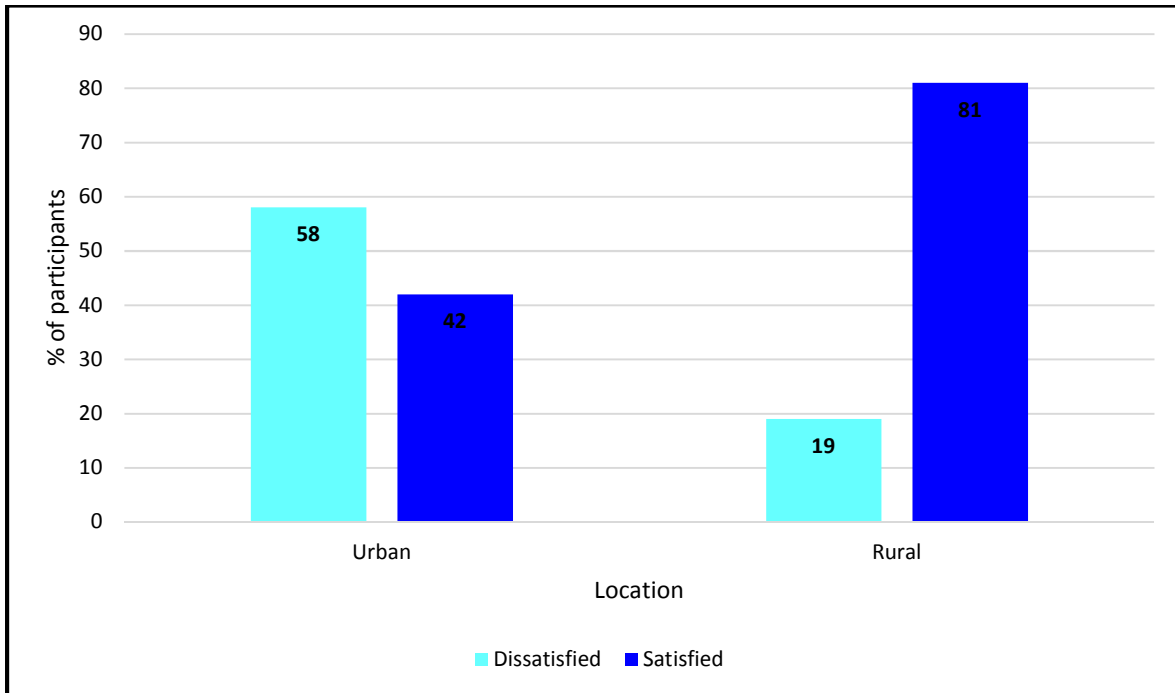
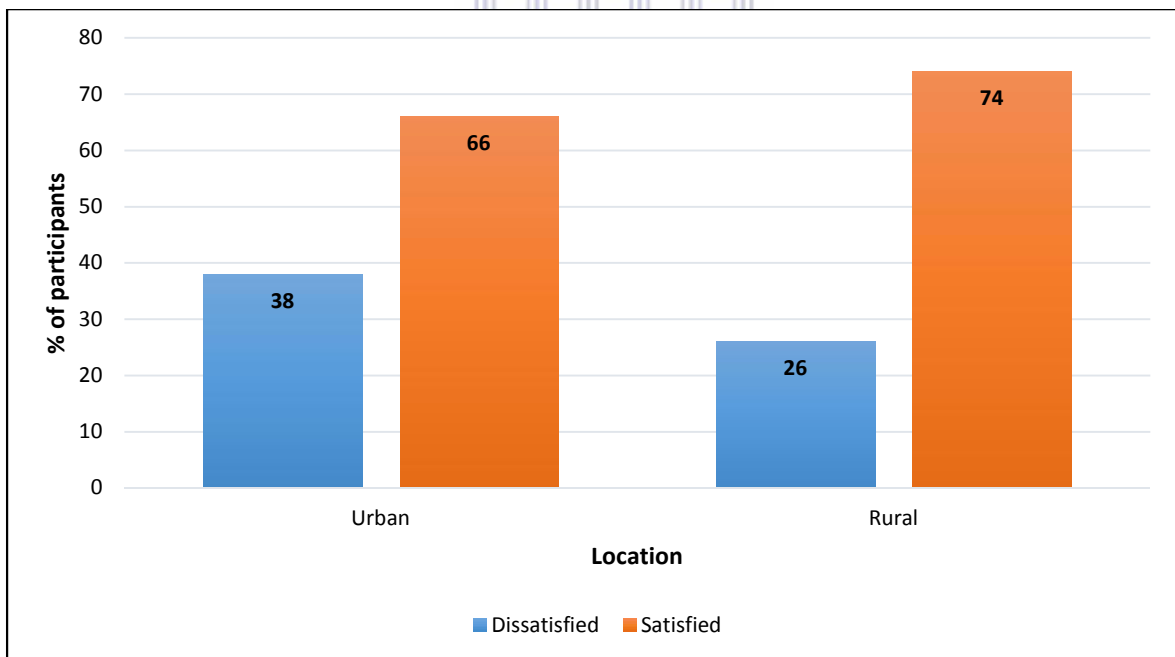


Figure 5.14 Satisfaction with physical environment responses in urban and rural areas (n = 96)

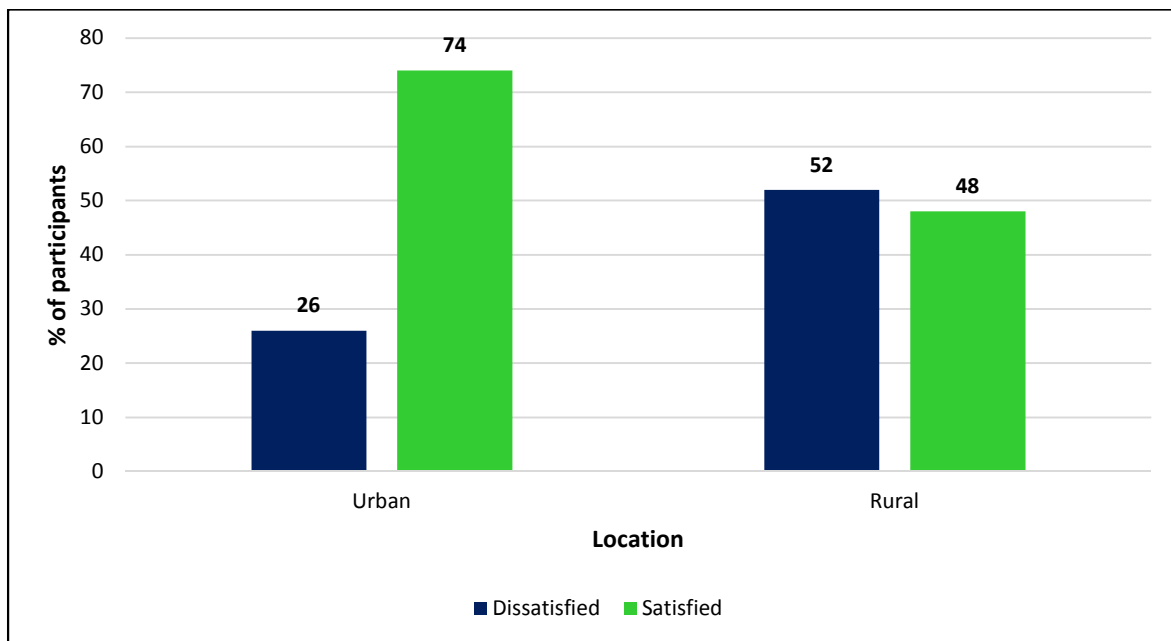




**Figure 5.15 Satisfaction with living environment responses in urban and rural areas (n = 96)**



**Figure 5.16 Satisfaction with access to health services in urban and rural areas (n = 96)**

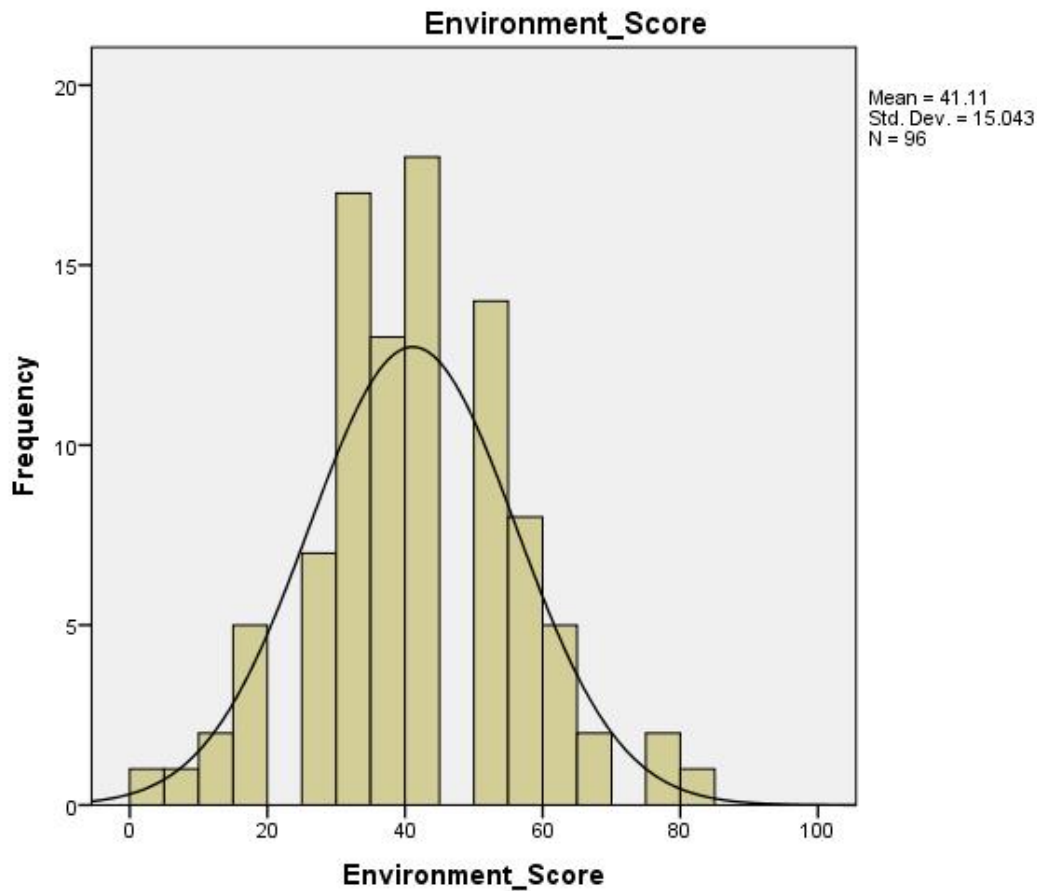


**Figure 5.17 Satisfaction with transport in urban and rural areas (n = 96)**

Table 5.5 presents the composite scores for this domain. The majority (81%) of the respondents scored below 50% indicating that their environment-related quality of life is low, as the higher the score the higher the quality of life. Only a few (19%) respondents scored above 50%. Figure 5.18 presents a histogram of these scores showing positive skewness (.048).

**Table 5.5 Environment domain composite scores**

Domain score %	Frequency n (%)
0-25	16 (16.7)
26-50	62 (64.6)
51-75	17 (17.7)
76-100	1 (1)



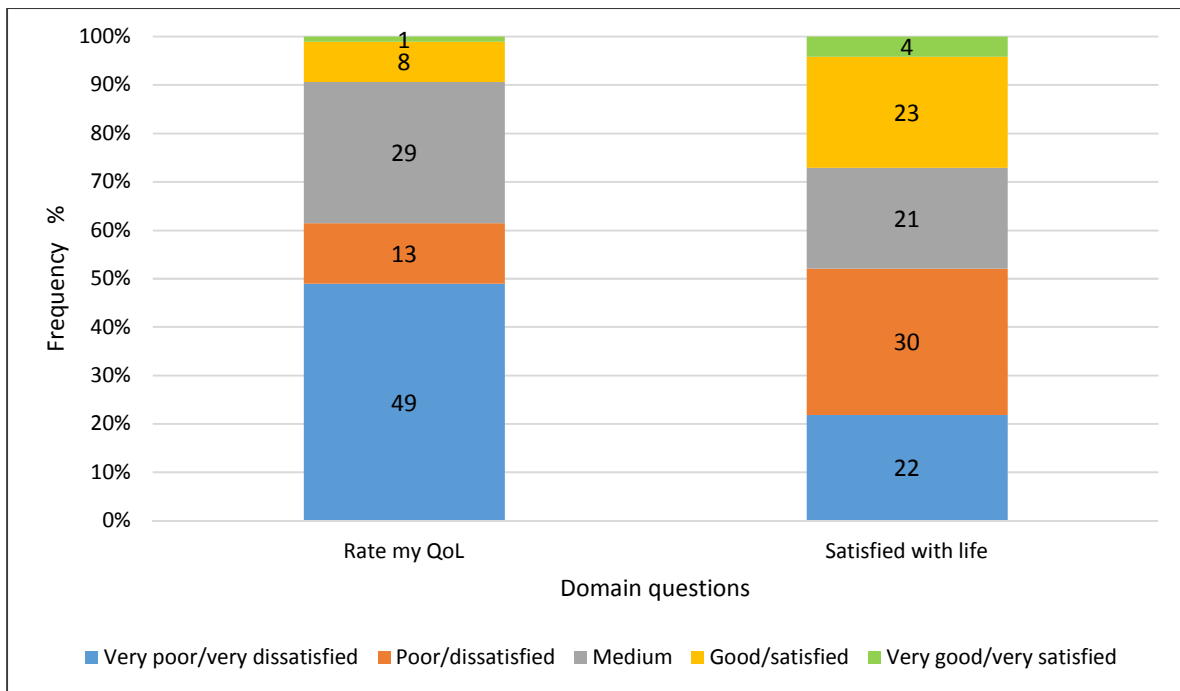
**Figure 5.18 Histogram of environmental domain scores**

### *General Quality of Life*

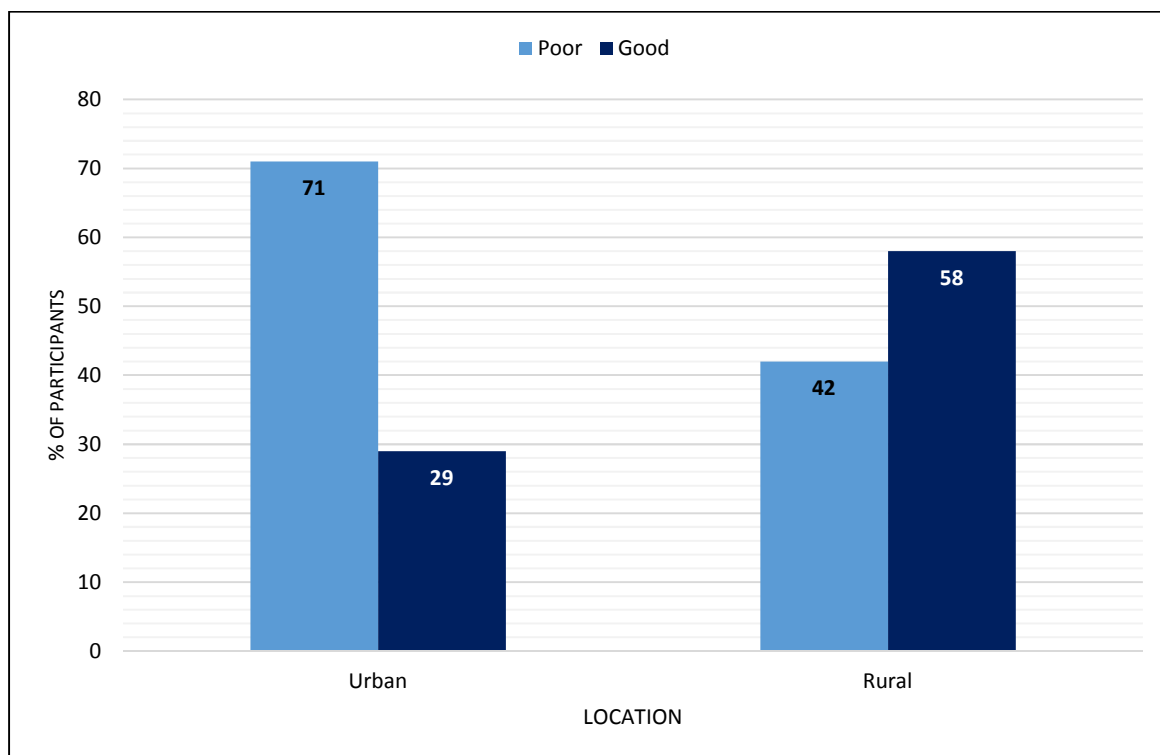
Respondents were asked to rate their quality of life and general satisfaction with life and these two items make up the general quality of life domain. Majority (62%) reported that they felt their quality of life was poor; 13% and 49% reported *poor* and *very poor* respectively. 29%, 8% and 1% reported *medium*, *good* and *very good* respectively. When comparing perceptions of quality of life by location, more participants in urban areas (71%) felt their quality of life was poor while more participants in rural areas (58%) felt their quality of life was good (see figure 5.19).

With regards to satisfaction with life, most (52%) respondents were dissatisfied with their lives; 30% and 22% reported being *dissatisfied* and *very dissatisfied* with their lives respectively. This

reveals that a large number of children and youths living in child-headed households are not happy with their lives. There was no significant difference between satisfaction with life between males and females.



**Figure 5.19. General Quality of Life responses (n = 96)**



**Figure 5.20 Perceptions of Quality of Life in urban and rural areas (n = 96)**

Correlations were conducted to examine the relationships between the general quality of life composite scores with the other four domains' composite scores. There is a weak relationship (Pearson correlation of .257) between psychological wellbeing and general quality of life for respondents in this study. Although respondents reflected to have poor physical health this did not affect their quality of life as there was no significant relationship between the two (correlation coefficient of 0.089). There was however, a moderate relationship between social support and general Quality of Life (correlation of 0.484). The composite scores of the two items were poor as most respondents (56%) scored between 26-50% which is low.

**Table 5.6 General Quality of Life composite scores**

Domain score %	Frequency n (%)
0-25	31 (32.3)
26-50	54 (56.3)
51-75	10 (10.4)
76-100	0

### Overall Quality of Life

The compounded domain scores represent the total positive and negative responses for each domain. The physical and psychological domains are largely positive with 66.7% and 67.4% positive responses respectively. The environment domain has responses with 50.3% and 49.6% respectively. The social relationship domain has more negative responses indicating dissatisfaction with social relationships and support. The general quality of life domain has the highest negative responses of 67.2% indicating great dissatisfaction with their quality of life. Table 5.7 presents composite scores for all 5 domains. A comparison of these scores shows that the social domain had majority of the low scores while the physical domain had majority of the high scores.

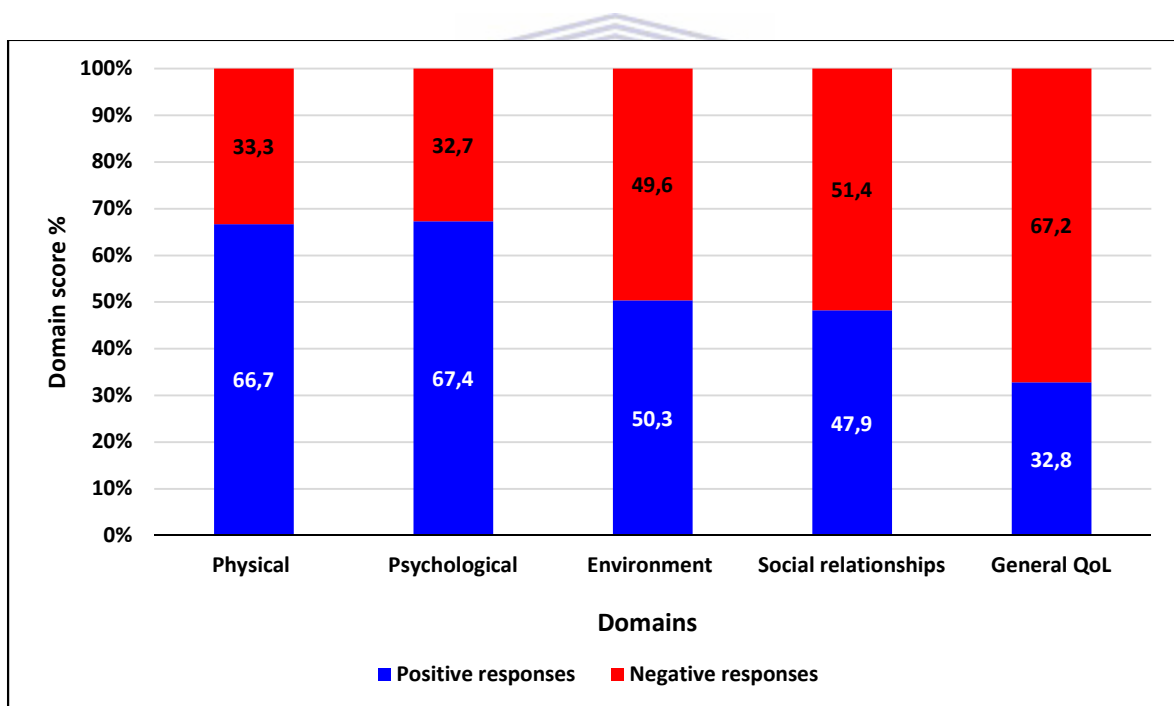


Figure 5.21 Compounded domain responses (n = 96)

**Table 5.7 Comparison of domain composite scores**

Domains	Frequency of scores n (%)				
	0-25	26-50	51-75	76-100	Total
Scores					
Psychological	8 (8.3)	29 (30.2)	51 (53.1)	8 (8.3)	96 (100)
Physical	2 (2.1)	17 (17.7)	61 (63.5)	16 (16.7)	96 (100)
Social	41 (42.7)	36 (37.5)	16 (16.7)	3 (3.1)	96 (100)
Environment	16(16.7)	62 (64.6)	17 (17.7)	1 (1)	96 (100)
General QoL	31 (32.3)	54 (56.3)	10 (10.4)	0 (0)	95 (99)

## 5.4 Discussion

The survey revealed that orphans living in child-headed households have generally positive psychological outcomes. Taking into consideration the experiences in the life trajectory of children living in child-headed households, positive psychological responses may indicate psychological resilience. Children were largely satisfied with themselves, their bodily appearance and felt their life was meaningful. Interestingly, female respondents were slightly more satisfied with themselves (82.5%) than male respondents (80%). Majority (65%) of participants also indicated that they felt life was meaningful, indicating hopefulness. More participants in urban sites indicated that they felt life was meaningful than those in the rural sites, with 71% and 58% respectively. Factors influencing these responses are unknown at this stage and will be explored in the qualitative phase. On the whole, these psychological results imply that children's traumatic experiences have not adversely affected their perceptions of themselves and of their lives, indicating a high degree of resilience.

There is however, evidence of *psychological distress* as participants indicated having negative feelings, difficulty in concentrating and some participants did not find life to be meaningful and did not enjoy life. This is not surprising, considering children's experiences of parental illness and death as well as the dynamics associated with the establishment of child-headed households. Children also experienced concentration problems which could be a result of these negative feelings. Interlinked to psychological distress are experiences of parental illness and death, caregiving roles, food insecurity, poverty and material deprivation, stigma, abuse and exploitation, no social support, rejection by relatives, friends and the community. These are all

factors that contribute towards children's psychological distress. Not having anyone to turn to for support, advice and to share the burden also exacerbates children's distress. There, however, was a weak correlation between psychological wellbeing and social support. Interventions to improve the wellbeing of children, in child-headed households, need to address children's psychological challenges, as evidently these affect their overall wellbeing and development.

In the physical domain, it is concerning that a considerable number (37%) of children experience physical pain that affects their daily performances and a similar number (34%) need medical attention to function every day. When these ailments are not treated, they may eventually develop into serious health conditions resulting in poor physical health outcomes for children. Furthermore, children performed very poorly in their overall domain scores as majority scored between 25 – 44%. This indicates poor physical health amongst children in child-headed households. Poor physical health may be attributed to poor nutrition and food insecurity, arising from poverty and the inability to afford adequate healthcare. There was no enquiry into children's HIV status, so it is not certain whether some of the children were HIV positive. They may have opportunistic infections and HIV related illnesses affecting their physical health.

With regards to mobility, 43% of the participants indicated that they were not able to get around on their own. This is contrary to expectations of children living in child-headed households being highly mobile individuals. This figure may consist of the younger children who may not be as mobile and independent as the older children.

A limitation of the WHOQOL-BY is that it does not assess the food security status of households which is crucial to an individual's physical wellbeing. There is therefore a need to explore child-headed households' food security status. Furthermore, there is need to improve and prioritise access and affordability of healthcare services for children living in child-headed households, in order to improve their physical health.

The lack of sufficient social support for orphans emerged as a critical issue influencing their quality of life. Children's social support network consists of relatives, friends, peers, neighbours and community members. The majority (70%) expressed that they did not receive the kind of support they needed from others, and similarly (66%) were also not satisfied with the support they received from friends. For child-headed households, it is understandable that these children do not have strong support from friends and peers, as children may have lost contact with friends



after dropping out of school. Children may also not have enough time to spend with friends amidst their caregiving and income generation responsibilities. Results from the environment domain, support this, as half (50%) of the respondents indicated that they did not have time for leisure activities. Furthermore, the stigma associated with their orphanhood may have affected children's friendships thus reducing the support they receive.

Although settlements are sparsely distributed in the rural areas, more participants (39%) were satisfied with the support they received from others, than participants in the urban sites (25%). This confirms the theory that support networks are stronger in rural settlements. Overall, social support and good social relationships are vital for children's quality of life. Poor performance in this domain is concerning, as it implies that children do not have many people to turn to, reducing their safety nets and coping capabilities, rendering them more vulnerable.

Safety and security is important for child-headed households as they are particularly vulnerable, because of the absence of an adult household member. Most respondents (67%) indicated that they felt safe in their neighbourhoods. More children in rural areas felt safe in comparison to those in urban settlements; this is expected as rural areas are closely knit communities who know each other and have strong kinship ties. Furthermore, villages often consist of clans, with neighbours being related. Rural areas also have a lower risk (lower incidents) of car accidents, muggings and house breaks, in comparison to urban areas. For urban dwellers, a sense of security is also dependent on the area and neighbourhood where one resides. For example, children living in informal high density areas are more likely to feel unsafe than those living in lower density areas.

However, 57% of children in urban areas indicated that they felt safe in their neighbourhood. This sense of security may be because of the living arrangements in child-headed households. Many child-headed households rent out rooms as a way to generate income; therefore many homes had adults living there although not part of the children's family.

In terms of satisfaction with the *physical environment*, most respondents (63%) felt that their physical environment was healthy in terms of pollution and general aesthetics. Children's view of the aesthetics of their environment, however, is subject to their exposure to other environments. Many of these children have only been exposed to their current (and similar) environment, therefore their yardstick is limited. More participants in the rural sites were

satisfied with their physical environment, compared to participants in the urban sites, with satisfaction scores of 81% and 55% respectively. This may be attributed to the fact that rural communities have a closer connection to the physical environment, depending on environmental elements of heat, rain, water and land for survival.

Similarly, more rural participants were satisfied with their living environment than urban participants. In total, over half of the respondents (54%) were satisfied with the conditions of their living place, although observations revealed that most houses were dilapidated and lacked adequate ventilation, water and sanitation. Some households had water wells while other households sourced water from their neighbours. In place of electricity, both in urban and rural settings, children used fire for cooking and paraffin lamps for lighting. Like many households in Zimbabwe, only a few households had solar panels and used solar energy for lighting and charging phones. The remaining 46% indicated not being satisfied with their living places, which indicates aspiration for a better quality of life.

Consistent with other studies (Germann, 2005a), 93% of the children did not have enough money to meet their needs. This corresponds with the children's socio-demographic information that indicates that over 90% of the households do not have a sustainable source of income. Child-headed households depend largely on hand outs and ad hoc livelihood activities. Many of these households struggle to put food on the table and most children have dropped out of school because of the lack of school fees. Poverty increases children's desperation thereby exacerbating their vulnerability.

It is clear that children living in child-headed households do not have adequate knowledge and information to make informed decisions in their lives. The majority (70%) felt they did not have access to the necessary information they require. This includes information on how to access birth and identity documents, social grants, counselling, healthcare services, education support and other social protection services. Access to information is also related to children's contact and interaction with the social system. Poor access indicates limited interaction between child-headed households and structures such as health, education and social welfare systems. This is surprising as Zimbabwe has a child protection committee system, which serves as the link between vulnerable children and these systems.

Only 49% had time for leisure activities. This is not surprising considering the caregiving and livelihood responsibilities of children living in child-headed households, particularly for the household heads. This corresponds with Germann's (2005a) study which also revealed that children living in child-headed households do not have adequate time to engage in leisure activities.

Two-thirds (66%) of the participants were satisfied with their transport situation, children and adolescents are highly mobile individuals. They have various modes of transport, walking, cycling and public transport. In the urban sites, participants were more satisfied with the transport situation than those in the rural sites, where most participants were dissatisfied. This may be attributed to remoteness of the areas that need public transport to get from point A to B. The rural sites for this study were newly formed settlements that were former commercial farms created under the Fast Track Land Reform Programme. One former commercial farm consisted of several villages with no public transport between them. Transport networks are still constructed around the commercial farm boundaries and not the new villages. The implications of this are that villagers have to walk long distances across the farm to a main road, to access transport. However, correlations indicate there was a weak negative relationship ( $r=-.251$ ) between access to transport and location.

Access to healthcare is essential for the wellbeing and development of all children. Access in this survey encompasses not only accessibility but also availability and affordability. It is impressive that the majority of the respondents (65%) were satisfied with their access to health services. Contrary to assumptions, more rural participants were satisfied with their access to health services than urban participants. This implies that they are able to access services at a clinic or hospital should they need to. Similar to the rural sites, the urban sites in the study were largely new settlements formed after Operation Murambatsvina, as well as informal settlements with poor services, few health centres and highly populated.

The number of respondents (34%) who were dissatisfied with their access to health services is concerning. This indicates the need to make health services, in terms of affordability and availability, more accessible to children living in child-headed households.

Overall, children living in child-headed households do not feel they have a good quality of life, just less than half (49%) feeling their quality of life was very poor and 13% feeling that it was

poor. Only 1% rated their quality of life as very good, which is very concerning. Based on the survey, factors contributing to children's poor quality of life include lack of money, psychological distress, poor physical health and poor social support. It is possible that there are other factors contributing towards children's dissatisfaction with their quality of life that were not captured by the survey. These factors will be further explored and discussed in the qualitative phase.

Perceptions of quality of life and wellbeing are subject to the environments and lifestyles that individuals have been exposed to. Despite the seemingly appalling living conditions, many respondents (64%) reported that they were moderately satisfied and quite satisfied with their physical environment. What becomes the individual's yardstick, in evaluating their own quality of life, is what they know. This is known as *social comparison*. Social comparison is when an individual compares him or herself to others; it is a defensive tendency that is used as a means of self-evaluation (Wills, 1981). This self-evaluation and assessment of one's situation is dependent on the reference group (Hyman, 1942 *in* Buunk and Gibbons, 2007). Aspiration levels are also relative to these reference groups (Clark and Senik, 2010). Arising from the limited exposure of the children in this study, there was less comparison to abstract others, and reference groups consisted of the community, neighbours and school peers. These communities were living in abject poverty as the study was conducted in Hopley, Epworth, two of the poorest peri-urban settlements in Zimbabwe as well as Chegutu, a resettlement area, formerly a commercial farming area. When comparing themselves to other poverty stricken households, children therefore felt they were relatively well off. For example, Tendai, who lived in a two roomed house, behind a beer-hole in Chegutu, with no running water and sanitation facilities, was content and rated his quality of life as *satisfied*. These findings make an important contribution towards understanding subjective wellbeing of children living in child-headed households.

## **5.5 Summary**

The survey consisted of 96 participants who were living in unaccompanied child and adolescent headed households in Harare, Chegutu urban and Chegutu district localities. The majority of the participants were between the ages of 10 - 17 years. Despite being orphans, living in child-

headed households and being in dire poverty, the majority of the participants showed evidence of resilience, as they had positive scores in the psychological domain, indicated satisfaction with themselves and their bodily appearance and felt their life was meaningful. However, a minority of the participants also indicated experiencing psychological distress such as depression and anxiety. In the physical domain, a few participants indicated experiencing physical pain that affects their daily performances and that they needed medical attention to function daily. Participants were dissatisfied with the support they received from others, including their friends, although the majority indicated satisfaction with their social relationships. In the environment domain, the majority of participants were satisfied with their physical environment but indicated dissatisfaction with their living environment. Overall, the majority of participants were dissatisfied with their life. Participants in the urban areas felt their quality of life was poor, while the majority of participants in the rural areas felt their quality of life was good.

These findings were qualitatively explored through an ethnographic inquiry, to understand how these factors influence participants' quality of life. In particular, issues taken up from the survey were: factors enhancing psychological resilience; causes of psychological distress; social support networks of child-headed households; as well as an exploration of the living environment of child-headed households. The next chapter discusses the ethnography.

## CHAPTER 6

### EXPLORING QUALITY OF LIFE

#### 6.1 Introduction

Following the Quality of Life (QoL) survey, an ethnographic inquiry was conducted. Findings from the situation analysis, in particular the context of a fragile state which include the collapse of the economy as well as health, education and social protection services, were further explored through a focused ethnography. The objective was to explore the factors affecting quality of life of orphans living in child-headed households. The ethnographic inquiry also sought to explain findings of the Quality of Life survey.

Several risk and protective factors influencing quality of life emerged. Risk factors are conditions that exacerbate children's vulnerability, reducing their quality of life, while protective factors, when present, are conditions or attributes in individuals, families, communities, or the larger society that mitigate or eliminate risk and increase health and wellbeing of children and families (Center for the Study of Social Policy, 2008). This chapter discusses these findings.

#### 6.2 Methodology

The objective of this phase was to explore factors influencing quality of life amongst seven children and adolescents living in child-headed households in rural and urban areas in Zimbabwe. This phase was an exploratory study that sought to obtain an in-depth understanding of themes that emerged in phase I and explain findings from phase II (the quality of life survey). A qualitative approach using ethnographic techniques was employed. A description of the study design, sampling techniques, data collection processes and analysis methods employed, is presented in this section.

### 6.2.1 Study Design

This phase applied ethnographic techniques to explore the quality of life of orphans living in child-headed households, from their perspective. Ethnography is a qualitative research approach that seeks to understand social phenomena from the actor's perspective, through extensive immersion in the actor's life-world (Subong, 2005). In assessing quality of life, great emphasis is on the individual's perceptions, as well as the context in which they live. The observable facts include the built environment, physical health, education and psychological state. These phenomena are best captured using ethnographic methods, which not only provide a holistic picture of children's experiences, but also capture the contextual environments.

### 6.2.2 Study population and sampling

Using the QoL survey findings, seven respondents were purposively selected for this phase. Both the sample selection and size had a great degree of flexibility, allowing the study to be shaped by emerging factors. Strategies for data collection in emergent research designs are open and depend on context (Suter, 2012: 343).

**Table 6.1 Profile of Participants**

Participant	Sex	Age	Household Head	No of household members	Orphan status	Year CHH formed	Location
Simba	M	20	Yes	1	Double	2008	Urban
Tendai	M	18	Yes	3	Single	2014	Rural
Promise	M	17	Yes	2	Single	2014	Urban
Clever	M	17	No	2	Double	2011	Urban
Rumbi	F	14	Yes	1	Single	2015	Urban
Nyika	M	19	Yes	1	Double	2010	Rural
Kurai	M	18	No	3	Double	2006	Rural



Table 6.1 presents the demographic characteristics of the study participants. Seven adolescents, six boys and one girl, took part in the study and their age range was between 14 and 20 years. As illustrated in the table, these participants were from Chegutu (rural and urban), Hopley (urban) and Epworth (urban) and were largely double orphans and household heads.

Simba is a very resourceful individual. Despite being a double orphan and struggling to find employment, Simba has not only managed to feed and clothe himself, he has also educated himself and currently provides for his young wife and one year old son. He has managed to do this by engaging in various livelihood activities, namely gold panning, construction work, fixing electrical appliances and recording music.

Similarly, Tendai epitomises resilience; at a young age, he became a household head and had to care for three siblings. From a situation of dire poverty and many deprivations, Tendai has managed to ensure food security and access to education for all his siblings.

Promise, only 17 years old, demonstrates a level of maturity far beyond his age. He looks after his young brother, operates a tuck-shop and attends private lessons to complete his high school education. In addition to good business acumen, Promise has commendable discipline for both his business and school work.

Clever has weathered the storm; he has endured losing both parents, neglect by relatives, extreme food insecurity and dropping out of school. Clever lives currently with his older brother in Epworth, Harare and although they are both not formally employed, this household is coping as the household's basic and material needs are met.

In contrast to Tendai, Rumbi epitomises a vulnerable orphan living in a child-headed household. Rumbi is 15 years old, recently lost her mother and lives on her own. In addition, she has no livelihood activity and is still trying to adjust and navigate her way through life as a child-headed household.

### **6.2.3 Data Collection**

Beham *et al.* (2006) points out that, quality of life measurement instruments, are largely determined by the theoretical assumptions, objectives of the study and level of analysis.



Therefore, to achieve the objective of exploring factors influencing quality of life in child-headed households a combination of two ethnographic tools were used; these included in-depth interviews and participant observations. Participants were interviewed first and then observed in their daily activities. In-depth interviews were used to probe on issues surfaced in the WHOQOL-BY survey; this included children's livelihoods, social support and isolation. In exploring issues of parental death and orphanhood, one-on-one interviews were the most suitable data collection method as the issues were sensitive and respondents would have been reluctant to discuss this in a group setting. By the time the interviews were conducted both parties (interviewer-respondent) were familiar with each other and the interviewer had already obtained the respondent's demographic details. The survey provided an entry point and time to establish rapport with the children before the interviews. Interviews were conducted in the children's homes to maintain a comfortable and familiar environment. They were conducted in Shona and recorded using a digital voice recorder. Children, heading households, received additional inquiry as the assumption was that household heads faced different challenges from the other siblings. Questions specific to child heads, ranged from issues of time management (time for work, leisure and school), the new roles of decision-maker and care-giver and most importantly social support for the caregiver.

Shadowing enabled the researcher to go deeper and acquire an emic perspective into the issue, as well as to triangulate data from the interviews. These data collection procedures were flexible, allowing them to be revised as the research progressed (Suter, 2012). Shadowing entails closely following subjects over a period of time, to investigate what they actually do in the course of their everyday lives, not what their roles dictate of them (Pickering, 1992). This data collection method was very intensive and challenging, as it involved continuous observation and writing extensive field notes. The researcher followed each child from very early in the morning and throughout the day, mapping the steps, interactions, and meals consumed and where possible, engaged in activities. Various aspects of children's living environment such as physical health, food availability, electricity availability and sanitation were observed. Through this technique, individuals, behaviours, opinions and actions were reflected on and resulted in rich and thick descriptive data giving a detailed, first-hand multidimensional picture (Quinlan, 2008; McDonald, 2005). Shadowing also helped identify discrepancies between what children said and

what really existed (Mays and Pope, 1995), complementing data obtained from the QoL survey, interviews and diaries.

A challenge with observations however, is being constantly on the move and relying on the researcher's memory for documenting large amounts of data at any one time. To address this, notes were taken whenever seated, and dictating reflections (on a digital voice recorder) whenever alone (Czarniawska, 2007). Furthermore, the researcher has considerable experience in ethnography and has a meticulous eye, and was therefore able to memorise and document field information. At the end of each day, field notes were expanded into descriptive narratives, while information was still vivid in the researcher's mind. Another practical challenge of participant observations is access, as respondents tend to get tired of being shadowed. The researcher had to continuously re-negotiate this access.

#### 6.2.4 Data Analysis

The narrative and voluminous data from interview transcripts, field notes and diary entries were transcribed and translated in to English. Using ATLAS.ti computer software, data was coded thematically and relationships between different themes were identified and analysed. Coding and analysis of the diaries and observations commenced during fieldwork, as observations involved thinking through what was being observed, why it was interesting and its categorisation (Gibson and Brown, 2009). Analysis during data gathering, enabled cross-checking of information (Thomas, 2007). Issues for further probing were identified and explored.

Using the WHOQOL framework and results from the survey, *a priori* codes were developed. These are pre-specified themes used as general categories to form a basic skeleton outline for further analysis. Empirical codes emerged from these *a priori* codes, for example in the *a priori* code of poverty, empirical codes that emerged were: the lack of sustainable household income; abandonment and loneliness. New themes also emerged from the gathered data.

Credibility was ensured through triangulation as this phase employed two data collection strategies: interviewing and shadowing. Adequate and detailed narratives of the observations from shadowing were produced to establish trustworthiness of the observations (Gibson and Brown, 2009). Data from shadowing was analysed while in the field and compared to the

interview data as a verification strategy; this helped to identify gaps of what was known and what needed to be known, thereby building the validity of the data (Morse *et al.*, 2002). As a result, this simultaneous process entailed prolonged engagement in the field. The researcher spent eight weeks in the field which further increased credibility of the data (Roberts *et al.*, 2006).

### **6.3 Findings: Factors Influencing Quality of Life**

This qualitative inquiry explored factors influencing quality of life in child-headed households, beginning with children's experiences of parental illness and death. In addition, the formation and living arrangements in these households were explored. These findings are discussed in this section.

#### **6.3.1 Formation and Living Arrangements of Child-headed Households**

The nature, composition and structures of child-headed households are diverse and range from accompanied to unaccompanied and from supervised to unsupervised. In this study, all seven participants were living in unaccompanied child-headed households, which are households with no adult member. Only Rumbi lived in a supervised child-headed household and was monitored by her older sister, who lived a few blocks away. She unfortunately could not take Rumbi in, as her husband did not want an additional "mouth to feed" so Rumbi was left to live on her own. Nonetheless, Rumbi would spend the day at her sister's house, where she would bath, eat and play and home was only a place to put her head down at night and keep her belongings.

The living arrangements of child-headed households are often an adaptation to challenges, such as lack of sufficient living space, inability to afford extra space, or as a food security, livelihood and financial coping strategy. The lack of sufficient space is evident in Tendai's household. He lives with only two of his siblings, while his other sister and her four months old baby live with their aunt in Chegutu. The home is too small to accommodate all four siblings and a baby. It is located behind a local pub that Tendai's father used to manage; when he passed away the pub owner let the siblings remain in the house. Observations confirmed this:

*The house is behind a beer-hole....it has 1 bedroom where Mary sleeps and a lounge where the boys sleep in*

Tendai's household is also a reflection of how some child-headed households form, not only as a result of orphanhood, but as a result of parents remarrying and moving away to start new families. Tendai's parents had separated when his father was alive and his mother had remarried. When his father passed away his mother could not take Tendai and his siblings. Tendai indicated that:

*her husband said he did not want children from another man, so we remained here living on our own.*

Similarly, Clever's household became a child-headed household long before their mother passed away. Initially, Clever lived with his father and his siblings, while his mother lived and worked in South Africa. In 2002 his father died, his two brothers went to work in South Africa and his sister got married, leaving Clever on his own. His mother came home every month, but fell ill and passed away in 2011. Now Clever lives with his older brother.

Nyika's living arrangement is an example of a living arrangements formed in response to food insecurity. Like Rumbi, Nyika lives alone at a rural smallholding he inherited from his parents but at the time of the study he was living with Madzibaba, a member of his Church and worked for him in exchange for food (daily meals).

For most of his life, Simba has been on the move, constantly changing his living arrangements. He currently lives on his own in Chegutu. Previously he lived with his parents and young sister, Sekai, when his father was working at a local mine. When the mine closed down, the family moved to another mine in Bindura. In 2000, Simba's father passed away and Simba and Sekai moved in with their maternal grandmother, who later passed away in 2005. Following this, the siblings went back to Bindura to stay with their maternal uncle. In 2007, Simba went to stay with his mother in Chegutu at their old house that the mine had given them before it shut down. In 2008 Simba's mother passed away, leaving Simba and Sekai alone. An older cousin moved in with them but later got married and moved out taking Sekai with her. In 2013 Simba married and he now has a one year old son. His wife is working in South Africa as a hairdresser. Although Kurai is only 18 years old, he, like Simba, has a wife and a one year old daughter.

Child-headed households not only consist of siblings, some child-headed households consist of a nuclear family as a result of early child marriages. In this study, two participants had families of their own, but only one was living with his wife and child. Kurai had a wife and one year old daughter and lived on the same plot with his older brother, Wishes and his family. These living arrangements have an effect on children's quality of life and wellbeing and will be discussed in the sections to follow.

### **6.3.2 Experiences of Parental Illness**

In the context of HIV/AIDS, many parents do not disclose their status to their children and relatives. Four study participants did not know the underlying cause of their parents' illness and death. A plausible reason for non-disclosure could be that most of the participants' parents died at a time when HIV/AIDS was still stigmatised and by not disclosing they felt they were protecting their children. Also, Francis-Chizororo (2008) asserts that parents' non-disclosure of their status and nature of illness, to their children, has deep roots in traditional Shona culture. Children are excluded from important matters as they are regarded as too young and therefore ignorant. Age is very important in most African cultures hence the clear distinctions between childhood and adulthood and the ceremonial recognitions when transitioning from one to the other.

On the other hand, looking at the maturity of participants and how HIV/AIDS is widespread and has ravaged communities in Zimbabwe, it is also possible that participants had an idea and suspected the reasons behind their parents' illness, and were in denial, or did not want to divulge this information. One participant, Rumbi was open about her mother's illness. Rumbi was aware that her mother had HIV as her status was well known in the community following the separation from her husband. Rumbi's father went on to live with another woman and was seriously ill. Contextually, it is understandable that Rumbi's mother's status was disclosed, as Hopley is a community with disturbingly high rates of HIV with almost every household being affected by HIV/AIDS in one way or other. Based on conversations with the Child Care Worker, who is also the Community Health Worker, most households had a member who was living with HIV. HIV

in this community has ceased being a stigmatised condition, as there is an element of empathy and shared experiences.

Furthermore, children and adolescents witnessed their parents' illness and were the main caregivers. Rumbi, Simba, Promise and Clever all witnessed their parents' illness and eventual death and looked after them during their illness. Rumbi's mother was constantly ill and in January she became seriously ill. Although her older sister would come to help, Rumbi was the main caregiver and often had to miss school until she eventually dropped out. She remarks that:

*I used to cook for her....my sister used to come and help me bath her and do her laundry.*

Similarly, Simba lived with his mother, a single parent as his father had passed away in 2000. As a result, when his mother fell ill, Simba was the only one who could look after her. Simba cared for his mother for about two months before she passed away in 2008. Promise's father had a stroke in 2012 and had to stop working. Promise looked after him but as his condition deteriorated, he was taken in April 2014, to their rural home and passed away in September of the same year. Clever lived with his brother in Epworth, Harare while their mother lived and worked in South Africa. When their mother became seriously ill, she came back home and Clever looked after her for only four days before she died.

*She had sugar<sup>7</sup>, it was caught late, she was sick then got better then got sick again and stayed 1 week in hospital in South Africa, when it got worse she was brought home and then she died four days afterwards.*

In the context of HIV/AIDS, orphans often experience multiple bereavements as parents die one after the other. This was evident in this study as Clever, Nyika, Simba and Kurai witnessed the death of both parents. For example, Nyika's parents were both ill for a long time and they each eventually died in hospital, months apart. Repeated loss means children experience a repetition of the trauma of watching their parent's illness and the grief of their death, which could have deleterious and long term psychological effects.

However, in child-headed households, it is important to recognize that HIV/ AIDS is not the sole cause of parental deaths. There are also other factors such as accidents and non-HIV related

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<sup>7</sup> Sugar refers to diabetes

diseases. In addition, the psychosocial dynamics differ between children caring for parents suffering from HIV-related illnesses, and children caring for parents suffering from other non-HIV related conditions such as strokes. HIV/AIDS can be debilitating and in many cases children watch as their parents fall ill, develop full blown AIDS and eventually die. This can be a traumatic experience for the young carers. In addition, children who care for HIV positive parents often evoke feelings of sympathy, pity and in some cases, can be stigmatised at school, in the community and extended family. For example, the community viewed and pitied Rumbi as a vulnerable young girl, and did not see the industrious girl who bravely assumed the roles of household head and caregiver for her ailing mother, up to her death. These are the psychosocial dynamics that this group of children have to navigate through.

On the other side of the coin, children caring for parents who have suffered a stroke or car accident are usually greatly commended and often evoke emotions of empathy and not pity. Family and community members feel a great need to help, as the perception is that unlike HIV, patients are not “blamed” for their condition as a stroke or accident can happen to anyone. They therefore offer their support for future reciprocity. This is evident in the communities’ perceptions of Tendai and Promise in comparison to Rumbi whose mother was HIV positive. While the community pitied Rumbi, Promise was seen as a hero yet both looked after their ailing parents, bathing, feeding and clothing them. This, no doubt, affects the children’s self-confidence and how they view themselves. The nature of parental illness and death therefore influence children’s wellbeing and how the household is perceived by the community and relatives.

Deaths by accidents and sudden illness are unforeseen. For example, Tendai lost his father unexpectedly in a car accident in 2012 and Clever lost his mother after a short illness. This sudden and unexpected loss of a parent and breadwinner can be a traumatic experience as children are not prepared, unlike when they witness their parents’ illness. Furthermore, the deceased do not get time to make arrangements for their children’s future and prepare them for life after their death.



### 6.3.3 Limited Assets and Resources

Retention of assets is crucial in any household to ensure present and future financial, physical and emotional security (Soto Bermant, 2008 *in* Evans, 2012). However, in households affected by HIV/AIDS assets are sold during illness to pay for medical costs and make up for the lost income. In the case of child-headed households, remaining assets may be taken by relatives after the death of parents. All seven households did not have many assets and resources at their disposal. Assets may have been sold by children or may have been taken by relatives. The main assets children had, were their homes, left to them by their parents. Six of the seven child-headed households, owned the houses they were living in. These houses provided shelter, safety and were a source of income for children.

However, Rumbi and Nyika's households have always been poor and lacked resources even before parental illness and death. Nyika's asset was the land that he was living on, which his parents had acquired before their deaths. However, due extreme deprivation, Nyika was not able to fully utilise this land as illustrated in the following excerpt:

*My entire life, I am a person who struggles.... we kept on moving as we had no land of our own until we got this smallholding...but I have not started growing anything in it yet as there is no equipment.*

### 6.3.4 Poor Housing Structures

Child-headed households lived in poor housing with poor water, sanitation and waste disposal facilities. Some of the houses were in a deplorable state and were constructed with metal scraps and asbestos sheets. For example, Nyika expressed that he did not have a proper house:

*There is nothing at home, not even a toilet. We do not even have a proper home, it is made out of metal tins.*

Being informal settlements, Hopley and Epworth have poor housing structures, with very small houses, approximately 200 square meters each, haphazardly spread out. Rumbi lives here in a two roomed house with an adjoining pit latrine toilet. Her toilet appeared unstable, as if it was about to collapse. Although these structures were permanent and long term, they appeared



makeshift and temporary and were vulnerable to harsh weather conditions such as heat, wind and rain as can be seen with Rumbi's toilet in figure 6.1. The level of poverty is reflected in the type of houses that participants lived in. Such living conditions are dangerous and contribute to poor health outcomes for these children.

Some child-headed households lived in well-built houses. Simba, Clever and Promise had strong and modern brick houses as their parents were employed and had stable incomes before they passed away. Although Tendai has a makeshift half-covered kitchen, his house was a fairly stable brick structure.



**Figure 6.1 Rumbi's toilet**

### **6.3.5 Poor Access to Water and Sanitation**

In most impoverished and informal settlements, sanitation is often inadequate and sub-standard and most child-headed households can only afford to live in such settlements. Hopley and Epworth are infamous for their poor water and sanitation since they do not have running water and sewerage reticulation. Most community members rely on self-erected wells and communal boreholes constructed during the cholera outbreak. Rumbi and Promise, who both lived in Hopley, fetched water from their neighbours' wells, while Clever, who lived in Epworth, had a

well at home, shown in figure 6.2. These water wells were mostly unprotected and untreated, and others were covered with asbestos sheets posing a health risk. Furthermore, the wells were at risk of contamination, as the two peri-urban sites had no proper storm water drainage and flood water could invade pit latrines and unprotected water sources.



**Figure 6.2 Water well at Clever's house**

Although Simba had tapped water, it was only available between 5 and 7 a.m. owing to municipal water shedding. By virtue of being in rural settlements, Nyika and Kurai sourced water from the river. Tendai used a community diesel generated water pump, in figure 6.3 below. They collectively purchased diesel for the pump. Although the water pump was located right outside Tendai's home, Tendai and his siblings sometimes went for days without water:

*We sometimes go for a week with no water, you see this water, the generator/pump uses diesel which everyone settled in the compounds and plots in this farm contributes money to buy. But sometimes they (the person responsible) cheats us and does not buy enough diesel for the month. So we end up fetching water 500m away.*



**Figure 6.3 Tendai's diesel generated water pump**

Of concern was the proximity of toilets to houses and water wells. For example Rumbi's toilet and house were less than the WHO recommended 30 metre separation distance. This poses a considerable health risk, especially arising from the risk of flooding and groundwater pollution of wells as pointed out by Nhapi (2009) and Manase *et al.* (2009). In addition, Hopley had poor solid waste disposal, as refuse was dumped in refuse pits, open spaces and along road sides close to houses as illustrated in figure 6.4 below. Children played in this rubbish.

With the combination of poor solid waste disposal, lack of storm water drainage systems, unprotected water sources and close proximity of pit latrines, it is not surprising that Epworth and Hopley were the epicentres of typhoid fever, cholera and diarrhoea outbreaks. These epidemics increased during the rainy season, as a result of pooling and stagnant water and rain water washing down solid and sewer waste. The stagnant water bodies also increase the potential for mosquito breeding, increasing the risk of malaria. Another driver of the triple epidemics was the proliferation of street vending outlets with cooked foods, fruits and vegetables.





**Figure 6.4 Waste dump in Hopley**



These three epidemics are very real in these communities. The researcher experienced this first hand, having suffered from acute diarrhoea and been quarantined for typhoid fever. This happened despite having taken all recommended precautions of avoiding purchasing cooked foods, washing hands regularly, using a hand sanitiser, avoiding handshakes and touching facial area with hands while in the field. Typhoid fever is a bacterial disease caused by *Salmonella typhi* and is transmitted through contaminated food and water. If typhoid fever is left untreated it can lead to death. Since October 2011, Zimbabwe has been experiencing sporadic outbreaks; in December 2014, the fever resurfaced and in May 2015 alone, 301 cases were reported. In addition, Zimbabwe has been struggling with cholera since 2008 when the year-long outbreak claimed more than 4,000 lives (IRIN, 2012). During fieldwork over 8,500 cases of diarrhoea were reported in July alone with a total of 220,000 between January and July 2015 (Ministry of Health and Child Care, 2015).

### **6.3.6 Issues of Safety**

Child-headed households are considered particularly vulnerable, owing to the absence of an adult member thus exposing them to higher risks of violence, sexual, physical and other forms of abuse. Three participants lived on their own and were vulnerable to break ins, in particular Rumbi, as she is female, young and lives in Hopley where crime is rife. The community was aware of this and were concerned for Rumbi's safety. As a protective measure, a neighbour sent their daughter to sleep at Rumbi's house every night.

When older siblings were away, engaging in livelihood activities, younger siblings were also vulnerable. In Tendai's household, Abigail, the youngest child was often left alone at night while Tendai went to work and his brother was at the tavern playing snooker. Abigail was terrified of being left alone, as the house was located behind the tavern and drunkards often wandered off to their house.

However, most participants indicated feeling very safe in their homes and in their community. From observations, the urban sites were densely populated and houses were close to each other. Most houses always had people at home during the day because of high unemployment. During fieldwork, neighbours would be sitting outside basking in the sun, conversing, doing hair, laundry and other household chores. Households were therefore always aware of movements and activities occurring at their neighbour's house. This was a protective mechanism for child-headed households preventing any burglaries and forced entries.

Although, households in the rural areas were sparsely distributed, being several kilometres apart, making it difficult to seek assistance and to monitor each other, participants indicated that it was relatively safe as crime rates were low and villagers had a code of conduct under the authority of the village herdsman. Furthermore, outsiders, such as the researcher had to report to the herdsman and the Ward Councillor. This safeguarded the community from criminal activities.

### **6.3.7 Food (In)Security**

Food security was a huge challenge for households in this study as children struggled to put food on the table. Six participants indicated that food availability was indeed a challenge for their

households. Shortages were more severe in some households than in others. For example Rumbi and Nyika experienced extreme food insecurity and did not have enough food in their homes to make up one meal. The excerpt below illustrates Nyika's situation:

*Life is really heavy. I've come to stay here because there is nothing to put in my mouth back home.*

Nyika's situation not only reveals his deprivation but brings out his *agency* as he temporarily moves in with another family and offers his labour in exchange for food. Similarly, we see this in Rumbi as she draws on her social capital to address her food security challenges. She remarks:

*I eat at my sister's house because there is no food to cook here.*

Food insecurity was particularly stressful for households with more than one household member, such as those with siblings. The following storyline illustrates this:

Promise: *Sometimes we have no food in the house and I spend the day without eating but I see that it's better that I starve than for Nomore to go to school hungry.*

Promise's storyline shows his struggle with food shortages and how he, in his parental role, makes sure, by his own self-sacrifice, that his brother does not go to school on an empty stomach.

Nonetheless, not all households experienced food insecurity. Tendai in particular indicated that he hardly experienced food shortages. He remarks:

*No not all. I buy food and also get vegetables from work. Well, sometimes groceries are short towards month-end.*

This reveals Tendai's resilience. Despite being an orphan and living in a child-headed household with three siblings to look after, Tendai has managed to ensure food security in his household, something many economically active adult-headed households in Zimbabwe are failing to do. Furthermore, it reflects the relationship between income availability and food security, the more income available the more likely a household is to become food secure.

Owing to the cross-sectional design of the study, it was not possible to fully capture the extent, in terms of duration and seasonality, of food scarcity in these households. Instead the researcher relied on observations and information provided by participants.

### **6.3.8 Birth Certificates**

Many orphans are not enrolled in school because they do not have birth certificates and identity documents, for those above 16 years of age. Acquiring identity documents such as birth certificates and identity cards is a huge challenge. A child is expected to come with their parent or guardian as well as produce their parents' identity documents and death certificates, which in most cases children do not have. Five study participants did not have identity documents and three did not have birth certificates.

### **6.3.9 Dropping out of School**

The loss of education in child-headed households is a very real experience, as children are confronted with caregiving responsibilities, financial constraints and psychological distress arising from their situation. All seven children dropped out of school either when their parents became ill or when they passed away. Rumbi dropped out of school in Form 1, when her mother became seriously ill and she nursed her until she died. Similarly, after his parents died Kurai dropped out of school to care for his young siblings who were aged two and four at the time. When his siblings were older, Kurai resumed school and completed his primary education with the support of the Basic Education Assistance Module (BEAM). However, Kurai was not able to complete secondary school as BEAM only supports with primary education. Kurai feels that had he completed school he would have been in a better situation and his quality of life would have improved.

The challenge of obtaining funds to continue with education is a reality for many orphans, particularly those with no guardians and relatives caring for them. As children enter the labour market, they miss out on school and eventually drop out. For example, Kurai started by doing

*maricho*<sup>8</sup> after school, as the household demands increased, he started missing school on some days until he completely dropped out. This is illustrated by the following excerpt:

*For fees, I used to fail to raise it and I would get thrown out of school and I would have to do more piece jobs until I could raise it... I used to miss school and go to maricho to get money for uniform and books.*

Nyika had to drop out of school in Grade 7 when his parents died and he started working to support his brother and sister. Similarly, Promise dropped out of school when his father was ill and could no longer work. He works in the tuck shop all day so he cannot attend school and instead he now has private lessons in the evenings. When his mother died, Simba dropped out of school and spent the whole of 2009 raising funds to continue with school. He resumed his studies in 2010 and managed to write and pass Ordinary levels (O Levels).

Similarly, Tendai and his siblings all dropped out of school when their father passed away but when Tendai found a job he managed to pay school fees for all three siblings. Only the youngest however, is still at school, as Tendai's brother dropped out because he had a large outstanding balance at school and his sister fell pregnant.

Furthermore, children indicated that the long distances to school deterred them from going to school. When schools are very far there are higher rates of absenteeism and drop outs. For child-headed households this is likely the case as there is no adult to supervise and motivate children to attend school. While discussing participant's access to education, they mentioned that prior to dropping out of school, they used to walk long distances from home to school and back. Kurai indicated that he used to walk 7 – 10 km to school. Simba noted that:

*...it was now very far and I used to wake up at 4am and leave home at 5am so that I get to school at 8am.*

In addition to school fees, distance becomes a barrier to accessing education for these child-headed households. Travelling to school is time consuming and becomes a burden as it takes up time for income generation and caregiving activities. For example, after walking 10 km from school, children still need to fetch water and firewood, cook, clean and engage in income-

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<sup>8</sup> Maricho – performing menial tasks for cash



generating activities all in a day. Children are therefore likely to forego attending school as the other activities are crucial for their survival.

### **6.3.10 Poor Health**

When asked about their physical health, most participants indicated that they were in good health. Observations corroborated this. Only two participants had some health concerns. Clever pointed out that he constantly suffered from migraines and also had a skin disease:

*I have a lot of headaches, which go for about two days and the pain is in the eye area. I also have a skin disease, it itches a lot, I sometimes apply medication and then it goes away then comes back again.*

From Clever's description, the skin condition he suffers from could be eczema or an allergy. During the time spent with him, Clever's headaches and skin problems did not manifest. Although Kurai said he did not have any physical health problems or concerns, there was an incident on one of the days when he had just returned from the mine. During a discussion, he almost collapsed and complained of feeling dizzy. This could have been owing to fatigue as a result of the extended hours he spends in the mine.

As discussed earlier, some children became caregivers and nursed their ill parents. This was in many cases a traumatic experience, especially for prolonged illnesses. Furthermore, witnessing the traumatic death of a parent can be quite distressful. All seven households had experienced the loss of at least one parent, and four households had experienced multiple bereavements as both parents had died. This alludes to the fact that by time child-headed households are established, these children are already carrying an emotional burden and experience some form of psychological distress.

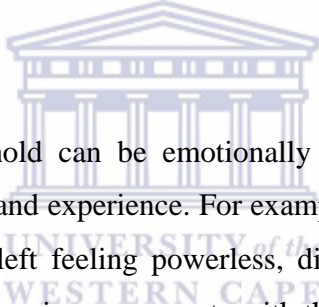
As child-headed households, the numerous and conflicting roles of school attendance, caregiving and livelihood activities as well as the act of balancing these can be overwhelming. In particular, child heads experienced a great deal of anxiety and worry. They often worried about where their next meal would come from, where to find employment, whether their siblings had enough to eat, and about their future. This is reflected in the following excerpts:

Rumbi: *Yes, I always think. I think about whether I will ever go back to school or this is the end.*

Tendai: *Sometimes, I think of Dad. Like now there is no one to cook for Aquiline, if Mum was around she would cook for her after school. And if Dad was alive we would all be in school.*

Promise: *Yes, I think about my young brother, whether he is comfortable amongst his friends and others, whether he has proper clothes and whether he is hungry, because he is quiet and doesn't talk so he won't say anything.*

Simba: *Yes I do, sometimes I think a lot, especially when I am on my own I feel like speaking to someone...sometimes I think that Dad if you were alive how would you deal with this situation, and when I have no money I think of my parents on how they would handle it.*



The stresses of running a household can be emotionally draining and devastating as these households have limited resources and experience. For example, when income generating efforts are unsuccessful children can be left feeling powerless, discouraged and anxious (Ward and Eyber, 2009). Nyika and Kurai's experiences resonate with this as their livelihood activities have in many cases been unsuccessful. Nyika's maize field was ravaged by cattle and efforts to seek employment resulted in him being exploited. The following excerpt illustrates his experiences:

*Sometimes they would give me \$10 instead of \$20 and some months they would not pay me anything, such that if I meet that person in the road I feel like fighting with him because it really hurt/pains me.... I think about it a lot...for me to know God it's because of the poverty I am in.... I mostly stay alone and start thinking a lot, these thoughts eat me up – like why am I living here on earth.*

In Kurai's case, he spends days working in the mines only to come out with nothing which discourages him. He remarks:

*...I think a lot about what I can do to make things work, I think about if only I could get money to sustain myself.*

Despite numerous counts of psychological distress, there was evidence of resilience amongst the child-headed households. A recurring concept in interviews and conversations was hope, participants had hopes and plans for the future. Hope signifies overcoming one's current challenges with a view of a better tomorrow. Despite previously not having had a livelihood, Promise, now attends private lessons and plans to write his O Levels. He intends to study Electrical Engineering and become an electrician like his brother. Similarly, Clever hopes to register for his O Level examinations and proceed to tertiary level.

### **6.3.11 Financial Insecurity**

As discussed earlier, orphans start to experience financial strain during their parents' illness and by the time parents die, household resources are depleted. The burden is carried over into the child-headed households. It is therefore not surprising that the predominant factor affecting the wellbeing and quality of life of children in the study was insufficient money.

Like many Zimbabweans, these children experienced difficulty in finding employment and their households were in extreme poverty. Of note is Simba, who has been applying for employment in mines across the country with no luck; he feels that because of the economic problems he is not able to secure a job in the mines which is further exacerbated by corruption and nepotism. Consequently he feels strongly that the socio-economic instability in the country is greatly affecting his quality of life.

This lack of money often translates into a myriad of challenges such as lack of food, dropping out of school and possibly homelessness as evident in all seven households. Rumbi and Nyika's households experienced extreme shortages of food as they had no money to purchase even a loaf of bread. The lack of sufficient income also resulted in children dropping out of school as they could not afford school fees and had to engage in income generating activities to sustain themselves.

### 6.3.12 Social Support

Older siblings not living in the child-headed households were an important source of social support, providing material and emotional support. Rumbi, Kurai, Nyika and Promise receive support from their siblings. For example, Rumbi has two older sisters and she relies on one sister for all her material support and for counsel. In addition, she has supportive neighbours, who send their daughter to sleep over at her house so that she is not alone at night. During the time spent with Rumbi, there were several community members who visited and came to check up on her. The recent passing away of her mother could be the reason that Rumbi was receiving a lot of community support.

Participants reported that they lost contact with their friends when they dropped out of school. Some participants indicated that their interests and concerns with their friends became different after their “parentification”. They established new friendships with other adolescents, heading households, in particular, Nyika, who became friends with Professor, as they had mutual challenges of being orphans and trying to make a living.

#### *Material Support*

In times of need, material support often comes from people closest to the household such as older siblings, relatives and close neighbours. Thus child-headed households depend on and reach out to the social networks closest to them. For example, Kurai’s first line of support is his brother who lives next to him. Similarly, Promise is supported by his brother, who set up the tuck shop business for him and occasionally sends money. Nyika reaches out to his sister for soap and toiletries.

In traditional rural and impoverished urban communities, there is greater solidarity and in other cases, a common challenge or need brings people together. For example resettlements such as Hopley and Epworth do not have piped water and electricity, so in the spirit of community and oneness, community members with wells, share their water with those who have not yet erected wells at their houses. This was evident in Rumbi and Promise’s households which did not have wells and Clever who had a well shared with his neighbours. He remarked:

*...others do not have wells so we cannot watch them go without water when we have water.*

In the present study, communities and relatives were not able to assist child-headed households as they were struggling with their own families. Kurai, Tendai and Simba in particular, repeatedly stressed that their relatives had problems of their own and were struggling to look after their families, thus were not be able to support them. Although Simba is in touch with his relatives, he indicates that, like him they are also poor and are struggling. Similarly, Tendai says he has good relations with his extended family but they are also struggling. He remarks:

*...they have their own children and families that they are struggling to look after also.*

As a result of not being in contact with relatives, social networks were also limited. In Nyika's case, he did not know any relatives. The family was too poor to travel and visit relatives and were constantly relocating because they did not have any land of their own until they received land from the land resettlement programme. As Nyika indicates:

*We do not even know a single relative, my parents died before showing us our relatives, but my father told us that our relatives are in Mhondoro - Ngezi but he did not tell us where exactly, but if we get money we will go and look for them.*

Clever and his brother lost contact with their relatives when their parents passed away so do not have any extended family to lean on.

*Ah our relatives, they only cared about us when our mother was still alive, when she died they did not even want to hear from us...*

### *External Support*

Not surprisingly, support from non-governmental and state institutions did not emerge as a major theme. As a result of the study's sampling procedures, all study participants were beneficiaries of the Department of Social Services' Child Protection programme. As discussed in the previous chapter, the Child Protection programme had Child Protection Committees (CPC) in all

communities. They were responsible for monitoring the wellbeing of all vulnerable children and child-headed households were a priority for these committees. The type of support rendered to child-headed households included monitoring children's safety and relaying their challenges to the Department. From observations, these weekly visits from CPC focal persons provided both emotional and social support as children talked and laughed with them. In addition, Kurai indicated that he received support from the Basic Education Assistance Module (BEAM) which paid his school fees for his primary education.

#### **6.4 Livelihood Strategies in child-headed households**

In response to financial constraints, child-headed households adopt various coping strategies. In the current study, participants engaged in a broad range of activities namely leasing out part of their houses, operating a tuck shop, selling sweets and vegetables, herding cattle, vegetable gardening, working as a farm labourer and a construction labourer, illegal gold panning, working in mine shafts, fixing appliances and recording music.

Leasing out rooms has become a common livelihood strategy for many households in Zimbabwe. In a cash-strapped economy, having an extra room in the house is an opportunity to generate income. Two participants, Clever and Simba survive on the rent money they receive. For Simba, in particular, this is his main source of income as he receives US\$70 a month from leasing out two rooms. Although this source of income seems stable and effortless, it has its toll; for example, during fieldwork Simba struggled to find a new tenant as the previous one had moved out. During observations, Simba went around looking for a new tenant; this involved telling neighbours, friends, people in internet cafes and his clients that he had a vacant room. Simba eventually found a tenant after searching for three months.

For Promise, his main source of income is the tuck shop that his brother set up for him. Promise and his young brother survive from this tuck-shop as it provides money for their school fees, food and toiletries. Although Promise operates the tuck shop, it is owned by his older brother who is the sole breadwinner of the family, as he also supports his mother and siblings back home in Rusape. Although his brother did the initial setting up of the tuck shop, it is Promise who made it grow and survived the economic stress. With no O Levels, this young man has made a

small tuck shop thrive in an impoverished community with abundant tuck shops. This has not been easy as running a tuck shop business entails monitoring of stock and regularly restocking with the “right” products. This requires maturity, discipline and a certain level of business and financial acumen, which Promise clearly possesses.



**Figure 6.5 Promise standing in front of his tuck-shop**

Child-headed households also engage in temporary and small piece jobs that come their way. In newly resettled urban communities such as Hopley and Epworth, construction work is abundant. Clever often works on construction sites as he remarks in the following excerpt:

*I sometimes work, putting floor tiles and as a builder in Glenwood around here in Epworth, the new stands. Someone comes to collect me and I work for him and he gets paid by the house owner and then pays me, but hey, these people don't want to pay good money...It depends on the size of the job, to lay a foundation I can get \$40 for a week's job.*



Simba, from time to time, also works on construction sites in Chegutu.

*Isn't when people are building they need pit sand. So we used to bring this pit sand to builders in a cart that we would push and then we would get money for the sand.*

Livelihood strategies in rural areas are often limited and are frequently related to agriculture. All three participants who lived in rural areas engaged in some form of agricultural activity for their livelihood. Tendai is formally employed as a farm worker and general hand at a smallholding, where his work includes growing vegetables, rearing chickens and driving a truck. Kurai's main livelihood activity is vegetable gardening and together with his brother Wishes, they grow tomatoes and rape, which they sell locally to community members. The vegetable garden not only provides income for Kurai, it also contributes to their food security as vegetables are readily available. However, at the moment Kurai is not growing vegetables as he does not have enough money to purchase seedlings and pesticides. He indicates that:

*Last year the garden did not do too well, because I had no pesticides. So the tomatoes did not do too well.*

*Maricho* and *Humwe* are common livelihood and survival strategies in rural communities. *Maricho* is performing menial tasks for a small cash payment while *humwe* entails the same tasks, only that payment is food. These tasks normally include clearing, ploughing, cultivating and harvesting fields. For the first two years of high school, Kurai paid his own fees with money raised from *maricho* for ploughing and cultivating fields. Nyika engages in both *maricho* and *humwe* as a livelihood strategy but these have not been successful, as Nyika has not been able to feed and look after his brother, who is now living with his sister.

At the time of the study, Nyika was engaged in *humwe*, working on a canal garden in exchange for daily meals. Previously, he was working in a nearby village herding cattle and earning US\$20 a month. Nyika left this job as he felt he was continuously being exploited by his employer, as he went for many months with no salary and if lucky he would only be paid US\$10. It is not clear whether Nyika's employer was exploiting him or if he was actually struggling himself and failed to raise enough money to pay Nyika.

In addition to vegetable gardening, Kurai works at a gold mine in his area. He is not formally employed but along with several other men, he has an agreement with the mine owner to

prospect for gold. If gold is found, it is split 50% between the mine owner and the team of miners. This coping strategy is hard for Kurai, as he spends 2 - 3 consecutive days at a time in the mine, only to come home with nothing. It is a labour-intensive activity yet the prospects of getting something are very low. Prior to his current job, Tendai was also involved in illegal gold panning. Gold panning is a common livelihood strategy in Chegutu and Kadoma districts as they lie along the Gold belt. Simba is also engaged in gold mining. He went to Mozambique and worked as an informal gold panner and managed to earn enough money to purchase a computer, which he now uses to record music. Simba operates a home studio where he records aspiring and amateur artists singing and burns<sup>9</sup> their music onto an audio CD for them. He earns an average of US\$30 a month from this. In addition, Simba repairs electrical appliances such as cell phones, radios and television sets.

Currently, Rumbi and Clever are unemployed. Rumbi has no livelihood activity, she is still trying to “find her feet” and deal with her mother’s death (she died in April 2015). Rumbi is also the youngest participant in the study which could also explain her poor resilience. Clever is also currently not working and is supported by his older brother whose income is able to provide for their basic needs: food, toiletries and clothing. Money from rentals also helps supplement his brother’s income. This is particularly useful when the takings from his brother’s business are low.

Lack of money is affecting participants’ ability to cope as child-headed households; Kurai, Nyika and Promise’s livelihood strategies are being hampered as they all required capital. Kurai needs pipes, seedlings and pesticides for his vegetable garden, while Nyika needs seeds and fertiliser for his maize field. Promise needs money to regularly and adequately stock his tuckshop.

Of all the study participants Simba had the most diverse livelihood. As discussed, he engaged in five income generating activities: gold panning, construction work, electrical repairs, recording music and leasing out his house. Although participants engaged in various livelihood activities, poverty remains a pervasive feature in these households. Only Tendai had a stable livelihood and source of income from working as a driver and general hand at a smallholding plot nearby. In Tendai’s context, he can be considered as “well off” as he is single-handedly running the

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<sup>9</sup> Burning – the process of transferring/ripping music from a computer to a CD

household, providing food, toiletries, electricity, school fees and clothing for a household of three, including his sister and her baby.

## 6.5 Subjective Wellbeing and Quality of Life

When discussing their quality of life, many participants repeatedly compared their current quality of life to that of when they first became orphans and started living in child-headed households. This indicates that quality of life changed along the trajectory from parental illness and death to child-headed households. Clever's storyline illustrates this:

*A lot has changed since Mum died, like the life has changed (the quality of life), money and even clothes... now it's getting better... We have also grown up and matured. We now also have a bit more money than then.*

Clever's remarks allude to the fact that when child-headed households are initially formed, quality of life may be poor. Children experience grief from losing a parent, possible social isolation with no support from relatives, multiple deprivation and psychological strain as they try to navigate their way round the notion of living in an unaccompanied child-headed household. In time, some child-headed households recover from this stage of shock, moving on to a resilient stage where quality of life improves.

Despite their current circumstances, participants also revealed hopefulness. When asked about his quality of life, Promise indicated that it was ok and he believed it could improve. He had a positive attitude and appreciated the little he had. For example, even though he had many challenges, Promise was always smartly dressed and tried to keep up with fashion trends. Promise did not allow his circumstances to define him instead he rose above them and worked hard to send his brother and himself to school and to enjoy the small things such as clothing.

Other participants revealed contentment. Tendai, who lived in a two roomed house behind a beer tavern in a resettled farm with no tapped water, was content with his life and felt the quality was good. His perception of a good quality of life may have been influenced by his surroundings of Chegutu, a small rural town and Kadoma, a gold mining city since he had lived most of his life between these two cities.

## 6.6 Discussion

The above findings indicate that children in child-headed households experience psychological distress as a result of multiple bereavements and the transition into child-headed households; challenges in school attendance; food insecurity; financial strain; and social isolation. Previous studies have shown that the challenges that orphans experience, begin well before parental death. In many instances, child-headed households are formed before parents die as children assume caregiving and breadwinning roles, when adults become incapacitated and these are referred to as accompanied child-headed households (Bequele, 2007).

Food security is often a challenge in impoverished households and child-headed households are no different. With limited livelihood options and scarce resources, children in these households struggle to put food on the table and in many cases, depend on community support.

Most children and adolescents in the study dropped out of school because of lack of funds for school fees. In addition to school fees, children need stationery and uniforms, which are often out of reach for child-headed households. Children therefore also drop out of school because they cannot afford uniforms and school stationery. The emotional stress of having to head a household, struggling to earn an income, living alone in fear and worrying about the next meal, also affect children's concentration at school and as a result, some children are too stressed to attend school. Others drop out as a result of the stigma and isolation related to being an HIV/AIDS orphan and a child-headed household (Gubwe *et al.* 2015).

The psychological stresses that children in child-headed households are exposed to are numerous and cannot be over-stated. These include the grief of parental illness and death, experiences with extended family care as well as the endless realities and challenges of living in a child-headed household. Along this continuum there are many other distressing challenges such as children's unmet need for love. Children in this study indicated experiencing distress as a result of financial and food insecurity and when they fail to provide for their siblings.

Furthermore, the absence of parents and adults to provide guidance, mentoring emotional and moral support exacerbates the situation. Cluver and Gardner (2007) point out that the lack of parental or guardian supervision is often associated with feelings of not being loved. This

highlights the significance of social support in the psychological wellbeing of children living in child-headed households.

In this study, poverty's vicious cycle manifests as poor access to nutritious food, healthcare, adequate housing and proper sanitation which all affect children's health outcomes. Studies have also shown that children living in child-headed households have poor health outcomes however, in this study the self-reported physical health was satisfactory.

Despite living in dilapidated houses with no water and electricity, children and adolescents had positive perceptions of their quality of life. This positive perception can be explained using social comparison theory and the concept of relative deprivation. Social comparison theory maintains that the assessment of one's status or situation is dependent on the reference group (Hyman, 1942 *in* Buunk and Gibbons, 2007). Owing to the limited exposure of children living in child-headed households in this study, there is less comparison to abstract others, and their reference groups were therefore largely their communities, neighbours, school peers and in some cases relatives. Perceptions of quality of life and wellbeing are subject to the environments and lifestyles that individuals have been exposed to; what individuals know becomes their yardstick in evaluating their own quality of life. Children referred and compared themselves to other households in their community when discussing their wellbeing and quality of life. Similarly, aspiration levels are also relative to these reference groups (Clark and Senik, 2010). These communities however, are entrenched in poverty and experience multiple deprivations, because of high unemployment and high rates of HIV.

Children may also have applied downward social comparison when reflecting on their quality of life. Downward social comparison is a defensive tendency that is used as a means of self-evaluation (Buunk and Gibbons, 2007). This is when a person looks to another individual or group that they consider to be worse off than themselves in order to feel better about their self or personal situation. Comparison with others is crucial in evaluating and constructing social reality (Buunk and Gibbons, 2007).

Relative deprivation emerges out of this comparison; this is when an individual, feels deprived based on comparison to the reference group. Runciman (1972) defines relative deprivation as when an individual is deprived of a status or commodity that other persons have and desires to have these assets. As a concept, relative deprivation was initially used by Stouffer *et al.* (1949) to

explain how background characteristics such as age, education and marital status influences soldiers' attitudes towards army life (Gurney and Tierney, 1982). Soldiers' attitudes differed depending on what group a soldier used as a standard of comparison (*ibid*). In this study, children and adolescents' perception of the quality of their lives was influenced by their community and neighbours who were their standard of comparison.

In addition, Wolbring *et al.*, (2011) also point out that life satisfaction is influenced by past experiences. An individual's past can also be his/her reference point of comparison. This was evident in the study when Clever referred back to the time when the child-headed household was formed comparing it to now. The present actions can only be understood and explained with reference to past events; adaptation and habit formation influence the present.

The relative income hypothesis argues that people make decisions based on relative income and view their own position in relation to others. Children that could not afford school fees but were able to afford daily meals therefore considered themselves well off, relative to other community members who did not have food and could not afford regular meals. Wolbring *et al.* (2011) conclude that the larger the relative income is, the higher the subjective wellbeing of an individual. Several studies have shown that relative income has a greater effect on happiness, wellbeing and life satisfaction than absolute income. Marx (1847: 163) in particular remarked "*a house may be large or small; as long as the neighbouring houses are likewise small, it satisfies all social requirement for a residence. But let there arise next to the little house a palace, and the little house shrinks to a hut*".

Children indicated having limited social support and social networks. This social capital is not available to many child-headed households, since the traditional safety nets have been overburdened and eroded by a combination of the burgeoning orphan crisis, economic instability and intensifying poverty. Studies (Ward and Eyber, 2009; Dalen *et al.*, 2009; UNICEF, 2001; Thurman *et al.*, 2006) have shown that children living in child-headed households often experience extreme social isolation with little or no support from the extended family and the community.

## 6.6 Summary

This chapter presented findings from the ethnographic inquiry. The lives and household dynamics experienced by seven children and adolescents living in unaccompanied child/adolescent-headed households were discussed. In particular, factors influencing their quality of life were explored: these include lack of resources, poor housing structures, poor living environment, food insecurity, and poor access to services. Furthermore, findings from this ethnography reveal the resiliency and agency of orphans living in child-headed households as they engage in creative coping strategies. The next chapter presents phase four of the study, which is the validation of the study findings.



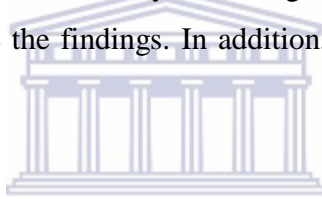


## CHAPTER 7

### VALIDATION OF STUDY FINDINGS

#### 7.1 Introduction

The previous three chapters presented the methodology and findings of phases I to III of this study – the situation analysis, quality of life survey and the ethnography respectively. Following these three phases, a workshop was conducted to validate these findings. This chapter discusses the validation process, it begins with a summary of findings from phases I to III followed by the methodology employed to validate the findings. In addition, themes discussed at the workshop are presented.



#### 7.2 Summary of Findings from Phases I-III



The point of departure for the validation of the study findings is a summary of these findings, which are presented in this section. The study followed a sequential multi-phase approach which included a situation analysis, a survey and a qualitative inquiry.

##### *Situation Analysis*

Significant issues that emerged from the situation analysis of child-headed households in Zimbabwe include i) weak kinships in some rural settlements influence the establishment of child-headed households; ii) poor physical health; iii) psychological distress in child-headed households ; as well as, iv) the existence of robust interventions to address the challenges of OVCs in Zimbabwe, including children living in child-headed households. These themes were further assessed and explored in the survey and qualitative inquiry respectively.

### *Quality of Life Survey*

The WHO Quality of Life survey assessed five dimensions of children's quality of life – physical, psychological, social relationships, environmental and general quality of life. 96 respondents were surveyed in the three study sites - Harare, Chegutu urban and Chegutu rural. Respondents indicated being satisfied with their physical health, they largely enjoyed life, found it meaningful, were able to concentrate with daily activities, and were satisfied with themselves and their bodily appearances. A considerable number however, indicated having negative feelings such as depression and anxiety, not being satisfied with both the support they receive from others and the support from their friends. Respondents reported that they felt their quality of life was poor and were dissatisfied their lives. Overall from survey, the issues affecting children's quality of life are: i) lack of sufficient funds; ii) lack of social support; and iii) lack of recreational and leisure time.

Domain composite scores were as follows: 61% of the respondents scored above 50% in the psychological domain; 81% scored above 50% in the physical domain; 20% in the social relationships domain; 19% in environmental domain and only 10% scored above 50% in overall quality of life. A summary of this survey was presented as a poster at the 19<sup>th</sup> International Conference on AIDS and STIs in Africa (ICASA) in Harare, Zimbabwe in December 2015 (AppendixIX).

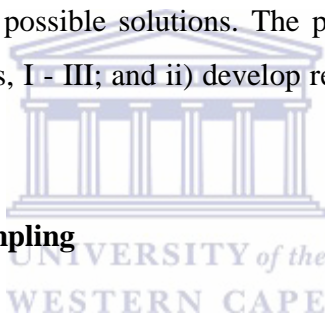
### *Ethnographic Inquiry*

The ethnographic inquiry went a step further and probed on the issues identified in the situation analysis and survey. Additionally, the inquiry investigated other factors influencing children's quality of life that may not have been identified in earlier phases. Children and adolescents experienced multiple deprivations characterised by poverty, food insecurity and living in poor dilapidated houses with no water and sanitation. In addition, children did not have access to essential services such as health care, obtaining birth and identity documents and social protection, such as school fees assistance. A graphic presentation of the number of children accessing social protection programmes is presented in appendix XI. This was also presented at the 19<sup>th</sup> International Conference on AIDS and STIs in Africa. Factors constraining access to

these services were identified to be geographic accessibility of services, affordability and transport costs, lack of knowledge of services available and the bureaucratic processes involved. In response, children and adolescents adopted creative coping strategies such as leasing out rooms, vegetable gardening and sourcing water from neighbours. See appendix X for a visual representation of the challenges and coping strategies adopted by children (also presented at 19<sup>th</sup> International Conference on AIDS and STIs in Africa).

### **7.3 Methodology**

This phase applied a participatory research approach whereby stakeholders were engaged and were involved in data production. As Bergold (2007) points out, participatory research involves both inquiry and coming up with possible solutions. The purpose of the workshop was to: i) validate study findings from phases, I - III; and ii) develop recommendations to improve quality of life in child-headed households.



#### **7.3.1 Study Population and Sampling**

Purposive sampling was used to select participants and the criteria were that the study population should consist of stakeholders from: i) a non-governmental organisation working with OVCs and CHHs; ii) a community-based organisation working with OVCs and CHHs; iii) a regulatory body; iv) a national organisation involved in policy formulation and implementation; v) an OVC research based organisation; and vi) the Department of Child Welfare and Protection Services as the custodians of child welfare in Zimbabwe as well as, vii) the ministries of health and education. Based on this criteria, purposive sampling was employed to select key stakeholders.

Organisations were purposively selected from a database of child welfare organisations provided by the Zimbabwe National Council for the Welfare of Children (ZNCWC). ZNCWC is the umbrella body of child welfare organisations in Zimbabwe and has observer status to the African Union (AU) Committee of Experts on the Rights and Welfare of the Child. Representatives from the selected organisations were then emailed and personally contacted. In total, two international child welfare organisations, three community based organisations, one regulatory institution, one

network, representing children and youth, one professional association, one research institution, one government/state department and a national organisation involved in policy formulation were represented. Stakeholders from the ministry of health and the ministry of education were unable to attend the workshop. Stakeholders were mostly directors and programme managers, including the director of ZNCWC. Appendix 8 provides a list of workshop participants and their organisations.

### **7.3.2 Data Collection**

A full-day workshop was conducted with all stakeholders with the researcher as the facilitator. The format of the workshop included a plenary session where the researcher presented phases I, II and III which included the objectives, methodologies and findings of these three phases. Stakeholders engaged and commented on the methodologies and findings. In addition, there was a discussion of challenges and coping strategies that did not emerge in the study as well as the policy response (or lack of) to these challenges. In this discussion, stakeholders shared their knowledge and experiences of working with child-headed households.

The second session consisted of interactive group discussions where stakeholders discussed recommendations to address the challenges and improve quality of life in child-headed households. This session was facilitated by the researcher with the support of the Programme Manager from ZNCWC. This was followed by a feedback session where these recommendations were discussed. The workshop concluded with a summary of challenges experienced by child-headed households, existing policy and programme responses and recommendations to address these challenges.

#### *Procedures*

The workshop was conducted at the Harare Bridge Club. Preparation for data collection included venue hire and set up, organising refreshments and stationery. A research assistant was employed to support the researcher. The assistant was a young male with a law degree who had previously worked for a child welfare based organisation and had experience in workshop logistics, including note-taking. The research assistant assisted in organising refreshments, workshop

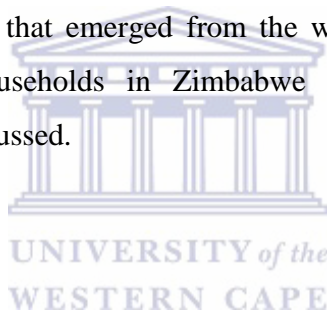
register, note-taking and transcription of the workshop proceedings. Additional support from the ZNCWC, whose offices are also located at the Harare Bridge Club, addressed venue set up and following up participants.

### **7.3.3 Data Analysis**

Proceedings, which included workshop minutes, flip charts and post-it notes, were collated and transcribed. Thematic analysis was conducted using Atlas.ti data analysis software and *a priori* themes were. In addition, new themes were identified.

## **7.4 Findings**

This section discusses key points that emerged from the workshop. Stakeholders pointed out challenges that child-headed households in Zimbabwe are experiencing. Existing social protection measures were also discussed.



### **7.4.1 Food Insecurity**

One of the greatest challenges that child-headed households in Zimbabwe are experiencing is food insecurity. In addition to poverty and low household incomes, the country is experiencing nationwide food scarcity because of poor agricultural harvests as a result of the “El Nino effect,” further compounding these children’s plight. Stakeholders indicated that like in many other vulnerable households, food insecurity will increase in child-headed households. One stakeholder remarked:

*in fact for food security we are likely to see it rising given that the drought is looming in particular areas maybe Harare may not yet be in that situation but places like Chirumanzu drought is already biting people with no food*

Stakeholders also raised concern over the difficulty in overcoming this challenge given that 2016 is a year of drought. Many households will be struggling, therefore the capacity of communities and other social safety nets will be stretched.

Social protection measures to address food insecurity include the Drought Relief programme which is only implemented once a “state of famine” has been declared. Stakeholders felt that child-headed households are likely to benefit from this intervention, as it first targets the most vulnerable households, child-headed households, widows and physically and mentally challenged people. One stakeholder remarked:

*you find that when the food gets to the communities usually these are the first groups to receive food then what remains is what is distributed*

However, one stakeholder pointed out the risks of political interference in interventions:

*that's the ideal set up but then this has a lot of political influence and interferences so there are also chances that the political structures might decide to do otherwise.*

#### **7.4.2 Child Labour and Exploitation**

Findings from this study revealed that children from child-headed households engaged in various livelihood activities to sustain their households. Stakeholders pointed out that this is considered child labour, if these children are below the legal age of employment. Importantly, this includes self-employment activities. As one participant pointed out that:

*....at times the child labour is in the form of that child trying to create income for themselves not necessarily employed by someone in terms of the legal definition of employment but they do work to bring income for themselves*

Child labour has implications on children’s physical and psychological health as well as on their developmental wellbeing.

Children from child-headed households are vulnerable to exploitation, as there is often no adult guardian to safeguard their rights. In many instances, community members exploit these child-headed households, who comply out of desperation. This is evident in the study as some children went for months without being remunerated.

### 7.4.3 Children Engaging in Illegal Livelihood Activities

A new theme that was not in the study findings, but emerged from the stakeholder workshop, was the illegal livelihood activities that children engaged in. Stakeholders indicated that many children from child-headed households engage in illegal activities as a livelihood strategy. In particular, a large number of girls from child-headed households engage in commercial sex work, while boys engage in petty theft and in some cases house burglaries. A stakeholder explained:

*Also, the issue of sex work comes into play. However, you find out that in a child-headed households there's a boy and a girl who are married to each other, the easiest way for them to get income - remember the article about dollar for 2 in Mukuvisi, the boy would let his wife to go and do dollar for 2 and she is fending the family, so that aspect. Maybe the ones that you sampled, but the majority of the girls are child prostitutes and child labour they even talk about it*

### 7.4.4 Child Marriages

An issue that often goes unnoticed is that of child marriages within child-headed households. Child marriages are of current interest in Zimbabwe; on the day of the workshop, there was a national march to abolish child marriages. It is often assumed that children living together in child-headed households are siblings or related; however, stakeholders pointed out that some child-headed households are formed as a result of children marrying one another. This is the case when a boy and girl below the age of 18 years co-habit, whether traditionally married or not, with no adult household member. Cases of child marriages in child-headed households in Zimbabwe are on the increase. A stakeholder noted that:

*you find out that in a child-headed households there's a boy and a girl who are married to each other*

Children in child-headed households are likely to get married or co-habit early, as they do not have a parent or guardian to restrict and/or advise them. These children are also out of school thus are likely to engage in social and sexual relationships earlier than school going children. In



addition, the assuming adult roles, gives child heads the illusion that they are “adults” and old enough to engage in other adult activities such as getting married. Some children get married as an economic coping strategy; children may decide to move in together to reduce the financial burden of rentals and other living expenses. This also acts as a safety strategy as living together also reduces vulnerability.

#### **7.4.5 Lack of Birth Certificates**

Many children living in child-headed households do not have birth certificates. This is a common challenge experienced by many orphans in Zimbabwe. Stakeholders stressed that this points to a larger challenge in the country. Many citizens do not have birth and identity documents and when they pass away, their children fail to obtain identity documents as their parents’ documents (birth, identity and death certificates) are required for registration.

There are various impediments to birth registration. The challenge is that to obtain a child’s birth registration certificate, both parents’ identity documents and marriage certificates (for married couples) are required. Firstly, for couples who are not married under civil law and do not have marriage certificates, a new born child is registered under the mother’s name. However, women are reluctant to do this, as this poses considerable challenges in the future. For example, should the couple separate, the child’s father and paternal family may refuse responsibility for the child since he/she does not have the father’s surname. Furthermore, it becomes difficult to claim maintenance as the child is registered under the mother’s name. As one participant indicated:

*I will give birth at the hospital and the facility is there but because I want my child to have the father’s surname but I don’t have a marriage certificate so if I try to take a birth certificate it will be in my maiden name and most women don’t think of the consequences because once you put your name on a child that’s big issues, in maintenance and all that, it’s complicated for women actually.*

Women would therefore rather not register their child until they have been married under civil law. Another male participant argued otherwise:

*That's not the issue, these people they go and deliver without money to pay the clinics so when they come out they are told there is nothing we can do for you before you pay your hospital bills.*

As a result, most women do not come back for their child's birth certificate. Secondly, some parents are of foreign descent, such as those who migrated from Malawi and Zambia do not have Zimbabwean identity documents so cannot register their children. A stakeholder remarked that:

*That's why you find in the farms many children from Malawi, and you know what, there are generations without IDs and you start going to the 5<sup>th</sup> generation to get that child a birth certificate.*

In such cases, parents may be asked to first renounce their foreign citizenship and, get Zimbabwean citizenship. They can then register their child, so parents would rather not register their child.

When children are orphaned and left as child-headed households, obtaining these birth certificates becomes a complicated undertaking. In addition to an accompanying guardian, children are required to produce their deceased parents' birth, identity and in some cases the death certificates, which they often do not have. The lack of a birth certificate therefore, becomes a barrier to accessing the much needed social protection services. These services require children's birth certificates before they can be assisted. It is as critical as preventing children from enrolling in school. This alludes to how bureaucratic processes and requirements may inhibit child-headed households from accessing social protection interventions. This emerged as a significant theme in the workshop.

#### **7.4.6 Social Protection Interventions**

In response to the plight of orphans, the State has implemented a range of social protection measures, under the National Action Plan for OVC that children living in child-headed households can tap into. These include educational assistance under the BEAM programme,

medical and healthcare assistance (Assisted Medical Treatment Orders), free health care for all children under five years, child protection services, family tracing and foster care placements.

The Basic Education Assistance Module (BEAM) provides block grants to schools to cover tuition for vulnerable children. An official from the Department of Child Welfare and Protection Services noted:

*we are referring children to the headmaster so that they can be placed on BEAM especially the child-headed families because there is what we call the OVC register, the child-headed households can be written in the register so that whatever assistance that may come they should have first preference, so you can see most of them we are referring to the headmasters, those that have dropped out of school they can be returned in school and placed on BEAM so that they continue with their education.*

The Department of Child Welfare and Protection Services works closely with the Ministry of Health to provide health care services to vulnerable children, through provision of Assisted Medical Treatment Orders. Children who cannot afford healthcare services are given a Treatment Order form that enables them to receive treatment for one year at any government primary health care facility. This service may be renewed. In addition, all government facilities provide free healthcare to all children under five regardless of vulnerability. Stakeholders noted that this free medical treatment was quite helpful for young children in child-headed households. There are also Village health workers that provide basic health services from which OVCs, including children from child-headed households benefit. A stakeholder also pointed out that the Department refers children to partner organisations that provide health and psychosocial support.

An intervention that specifically targeted child-headed households is foster care placement. In circumstances where child-headed households are in dire and deplorable conditions, the department of Social Services places children with families, under foster care.

Central to these interventions is the new model of Child Care Workers (CCWs) who are community-based volunteers. An official noted that they are:

*working on voluntary basis to look on the welfare of children in their communities including these child-headed households so if any child is facing problems in their communities, these foot soldiers or cadres are there to address these problems, they can link them to the services that are needed and can refer some of the cases to our district offices for further management.*

#### **7.4.7 Bureaucracy Inhibits Access to Social Protection**

As discussed above, there are several social protection services for OVCs that orphans living in child-headed households can benefit from. However, lengthy bureaucratic processes limit children from accessing these services. In particular, Treatment Orders for medical fee waiver and BEAM for school fees assistance, require children to produce certain documentation or referrals by Community Child Care Workers (CCWs). The BEAM programme requires children to produce birth certificates, which, as discussed earlier, many orphans in child-headed households do not have. In response to the challenges of obtaining birth certificates, the Department of Child Welfare and Protection Services is facilitating this process by working with the Registrar General's office. Furthermore, the department provides orphans with letters to use in places where birth certificates are required, such as school enrolment.

These bureaucratic loops were reiterated by a participant who explained the process children go through when trying to obtain a Treatment Order:

*The long process is that they have to take a bus and go to the Welfare Centre to see a DSS district officer, who has to come back and assess whether that's the situation, after assessing they write comments and make recommendations.*

Another participant noted that in many instances when orphans try to obtain social services, they are turned away and told to bring a guardian. This is particularly difficult for children living in child-headed households who may not have a guardian willing to assist and accompany them.

Stakeholders also alluded to political interference in social protection programmes, which often results in diversion of funding and resources or a change in the target group. When referring to drought relief interventions, a stakeholder remarked that:

*this has a lot of political influence and interferences so there are also chances that the political structures might decide to do otherwise.*

#### **7.4.8 Insufficient State Resources**

As a result of prevailing macro-economic challenges, the State has been inconsistent in supporting OVCs. This inconsistency is both at budget allocation and implementation levels. Programmes are implemented unevenly throughout the country with some districts being left out. There was mention of how some OVC programmes, such as BEAM were not implemented in some districts, as the funds were not sufficient to roll out the programmes throughout the country. Furthermore, BEAM was not implemented countrywide in 2015 because of financial constraints. As a result, most recipients of BEAM scholarships dropped out of school in 2015, as these are children in difficult circumstances with no alternative support. As a stakeholder expressed:

*I'm glad the Officer was able to acknowledge that 2015 there was no BEAM assistance because from a civil society point of view, 2015 was bad, a lot of organisations reported their children were not picked for BEAM. They were just acknowledging there was no budget allocation from the Ministry of Finance through the Department of Social Welfare.*

Furthermore, the state does not have sufficient resources for its CCW model as they are overloaded and not remunerated. The workload and expectations from CCWs is quite high as statistics provided by a stakeholder showed that Harare district has 172 CCWs with a distribution of 3 - 5 CCWs in a ward of 20,000 - 30,000 households. As a result, these CCWs often walk over 20 km a day to cover these households and sometimes further when taking a vulnerable child to Department of Child Welfare and Protection Services offices. Furthermore, stakeholders stressed that the CCW model falls short in its failure to remunerate these “foot soldiers”. Theirs is a critical role in the National Case Management System and the care and protection of OVCs in the country. A stakeholder expressed dissatisfaction with the support CCWs are receiving and remarked to the official:

*But then the issue of CCWs, we said they are volunteers and so are vulnerable... now all your work is centred on the CCWs so can you do something so that he or*

*she can work in a good environment because you can't say I'm working and you don't have any money for food and transport, you can't expect someone to walk 40 km, why? because they don't have resources, do something please, surely!*

The official responded by pointing out that the department acknowledges the challenges that CCWs experience and has responded by providing bicycles that CCWs use as a mode of transport, to enable them to carry out their respective duties. The Department of Child Welfare And Protection Services also has emergency funds that CCWs may access when they need to urgently refer a child.

State departments are still paper-based and not yet computerised thus it is not easy to link different interventions and track their progress, for example linking social services with health or education interventions. As a stakeholder pointed out:

*I think that's one area they need to work on, computerising the system so that they can even pick people who are double dipping.*

#### **7.4.9 Children Falling through the Cracks**

A theme that not only threads throughout all the other themes, but ties them all together is that children living in child-headed households are “falling through the cracks”. This particular group of vulnerable children is often missed in interventions that target OVCs, yet they are very vulnerable. Most children in child-headed households are not reached in interventions because i) they are often unaware of interventions, as their access to information is limited, as evidenced in the quality of life survey; ii) they do not have the requirements such as birth certificates; and iii) they are often undocumented as they are very mobile and difficult to track down. They are therefore commonly referred to as an invisible population. This is particularly the case for unaccompanied child-headed households that do not have an adult guardian. As one stakeholder remarked:

*child-headed households that are accompanied, which are supervised, they get more privileges than those who are not accompanied, they are talking about BEAM, it's just a drop in the ocean, there are so many child-headed households of which you can see that only three out of all the child-headed households get BEAM*

*assistance why, because they are supervised, they have got someone who is older and can supervise and accompany them, those who don't have don't get, surely there's a gap out there."*

According to the stakeholder from the Department of Child Welfare and Protection Services, children from child-headed households should be benefiting from BEAM, as they should be in the OVC registers which are used for the selection of recipients. In addition, CCWs and CPCs should refer and recommend children from child-headed households for BEAM support. In the ideal setup this should be the case, in reality however, the factors mentioned earlier come into play and inhibit many child-headed households from being listed in the OVC registers.

## **7.5 Summary**

This chapter presented findings from the validation workshop. Stakeholders confirmed that children from child-headed households experience food insecurity, difficulty in obtaining birth certificates and are often left out of social protection interventions. In addition to these challenges, stakeholders identified other challenges experienced by children that did not emerge from the study. These include child labour, child marriages and involvement in illegal activities. The next chapter presents a comprehensive extensive discussion of the major findings of the study.



## **CHAPTER 8**

### **DISCUSSION**

#### **8.1 Introduction**

The challenges experienced by children living in child-headed households are not well understood; they are a particularly vulnerable group of OVCs as they do not have guardians and are often left out of interventions targeted at OVCs. They often “fall through the cracks” as they are undocumented and difficult to trace, hence they are referred to as an “invisible population”. It is on this basis that this study assessed the quality of life of children living in child-headed households in Zimbabwe. Factors influencing children’s quality of life were also explored.

This chapter presents a discussion of the components of the quality of life of children, living in child-headed households. In addition, factors influencing these components are discussed. In the discussion, a rights-based approach is applied using the United Nations Convention on the Rights of the Child (UNCRC) 1989 to highlight whether the rights of children living in child-headed households are being met.

#### **8.2 Discussion**

This study has identified seven key factors influencing the quality of life of children living in child-headed households in Zimbabwe; some aspects diminish children’s quality of life while other aspects have protective benefits that improve their quality of life. These factors are considered significant, based on their immense implications on the quality of life of children in child-headed households. This discussion is centred on these risk and protective factors.

## 8.2.1 Risk Factors to Quality of Life in Child-headed Households

Risk factors affecting quality of life identified in this study were lack of birth certificates; failure to realise education; food insecurity; poor housing, water and sanitation and failure to access and utilise healthcare services. These risk factors reflect the violation of these children's rights as stipulated in the 1989 Convention on the Rights of the Child (UNCRC), particularly the right to: i) birth registration (*Article 7.1*); ii) education (*Article 28*); iii) access to healthcare services (*Article 24.1*); iv) adequate nutritious food and clean drinking water (*Article 24.2c*); and v) a standard of living adequate for the child's physical, mental, spiritual, moral and social development (*Article 27.1*). This is exacerbated by the absence of an adult guardian to enable, protect and safeguard these children's rights. This section discusses, in light of these five UNCRC rights, the multiple deprivations and vulnerabilities experienced by children living in child-headed households.

### i. Failure to Obtain Birth Certificates

A colossal challenge experienced by children living in child-headed households is obtaining birth certificates. In this study, children confirmed that acquiring identity documents such as birth certificates and identity cards is a huge challenge. This is a critical and widespread challenge throughout sub-Saharan Africa as half of the continent's children are not registered at birth and do not have birth certificates (UNICEF, 2013). Barriers to accessing birth certificates in child-headed households include a) poor knowledge of the importance of birth certificates; b) financial constraints; c) lack of required documentation such as parents' birth and death certificates as well as, d) parental issues.

#### a. Poor Knowledge

Poor knowledge and understanding of the importance of having a birth certificate and an identity document may prevent children from obtaining birth certificates. This may also be the reason their parents did not obtain certificates for them when they were alive. Other than knowledge, children in child-headed households have more critical needs such as food production and

earning income. As UNICEF (2002) appropriately indicates, birth registration may not be a priority for families struggling to survive.

*b. Financial Constraints*

Obtaining a birth certificate entails direct costs and indirect costs (PEPFAR *et al.*, 2008) which children in child-headed households cannot afford. Direct costs include paying for the registration and for the issuing of the certificate, although this is free or minimal in most countries in sub-Saharan Africa (UNICEF, 2002). The indirect costs are the significant barriers which outweigh direct costs. Firstly, children, and their parents, before passing away, would have to travel to the nearest district or provincial office in order to obtain a birth certificate. They would incur transport costs which can be quite substantial particularly for those living in remote rural areas. Children may have to return several times between lodging their application and being issued their certificates, doubling or tripling their transport costs. This finding is consistent with the existing literature that shows that financial constraints inhibit obtaining birth certificates. As a UNICEF study shows, direct and indirect costs are barriers, in 20 developing countries, to birth registration and obtaining certificates (UNICEF, 2009). In addition, a study conducted in South Africa shows that poor rural communities had fewer birth registrations, compared to more affluent urban communities. Giese and Smith, (2007) support the argument that poverty and limited financial resources are barriers to obtaining birth certificates.

Stakeholders in the workshop also indicated that many women do not obtain birth certificates owing to outstanding hospital bills. Although the birth has been registered, the certificate is held until the parents pay the hospital bill for the delivery of the child. As a result of poverty and competing financial obligations, such as food security, sending children to school and medical costs for households affected by HIV, parents may never return to settle the outstanding bill, leaving children to grow up without birth certificates.

Opportunity costs such as livelihood, food production and caregiving time also deter children from obtaining birth certificates. As mentioned above, the process of obtaining birth certificates is often long and cumbersome and children, heading households, may not have time to spare.

This would mean losing out on one or two day's work which translates into lost income (UNICEF, 2002).

*c. Lack of Documentation*

The most cited reason for not obtaining birth certificates in the current study was lack of required documentation. Children reported being turned away from registration offices, owing to lack of sufficient documents. In Zimbabwe, the prerequisite for obtaining a birth certificate are the child's birth record if born in hospital, parents' birth certificate or identity card, death certificates for deceased parent(s), sworn affidavits from both maternal and paternal relatives confirming the parents of the child (Legal Resources Foundation, 2004). For children living in child-headed households, these documents may be difficult to obtain; participants in the current study cited the following reasons: parents did not have birth certificates and identity cards; parents passed away while children were too young to know about death certificates or the location of their parents' birth certificates and identity cards; children moved and lived with different relatives after parents passed away and do not know the location of their parents' documents; and children lost contact or do not know their relatives.

*d. Parental Issues*

The stakeholder workshop identified paternity and maintenance issues as crucial barriers to obtaining birth certificates for children. In cases where paternity is contested, mothers delay registration, hoping to register the child once this is resolved. In addition, according to stakeholders, without a marriage certificate and the father's identity documents, a child is registered in the mother's surname. This is however a challenge when claiming maintenance and this often deters women from registering their children.

Birth certificates are fundamental in realising numerous children's rights. These include: the right to nationality, access to healthcare and education, safeguarding against exploitation, abuse, child labour and early marriages, enabling property inheritance, family tracing, and other citizen rights such as obtaining a passport, voting and opening a bank account (UNICEF, 2002). The

lack of birth certificates amongst children living in child-headed households is a denial of this right. In terms of quality of life, children's vulnerability increases without a birth certificate: they are unable to access social services; they are at risk of child labour and abuse; and they are unable to claim their inheritance.

Firstly, birth certificates and identity documents establish a child's identity and serve as proof of citizenship, so a child without a birth certificate is without legal existence (UNICEF, 2002). Without proof of citizenship, it becomes difficult for children to access essential services in addition to social protection measures. Children in the study indicated that they could not access social protection measures such as BEAM and could not enrol in school and write examinations because they do not have birth certificates. This is the case in many countries as birth certificates are prerequisites to school enrolment (UNICEF, 2002). This is evident in Togo, where a survey conducted by Plan International showed that children with no birth certificates were unable to write final primary school exams and thus were also unable to proceed to secondary school (Bequele, 2005). In Tanzania, a birth certificate is required for enrolment into university and consequently a child without a certificate is unable to enrol.

Secondly, without birth certificates it is difficult to safeguard and promote the rights of children. Bequele (2005:8) stresses that "proof of age is an important first step towards protecting children and in the promotion and realisation of their rights". A birth certificate provides proof that the child is indeed below the age of 18, as laws protecting the rights of children are only applicable for persons aged 18 and below (PEPFAR *et al.*, 2008). In such cases, legal protective measures and minimum age of criminal responsibility for these children becomes difficult to apply (UNICEF, 2002:5). For example, without legal proof of age, it is difficult to enforce the ILO Convention on minimum age of work (1973). Children without birth certificates are therefore more vulnerable to child labour, military conscription, trafficking and child marriage. UNICEF (2002) points out that a child, with no official identity or proven nationality, can therefore remain hidden and unprotected and is likely to be more attractive to traffickers.

Thirdly, for orphans, the lack of legal proof of identity has far reaching implications, as it inhibits them from receiving their inheritance which may be taken from them by relatives. In order to claim inheritance a child needs to provide a birth certificate which connects the child to

the deceased. For example, in verifying land and property rights, birth certificates together with parents' death and marriage certificates are required (Rose, 2007).

At policy and planning levels, birth certificates provide the much needed information on the age of children living in child-headed households. This complements surveys and statistics, enabling improved and informed planning for social welfare, health and education services. Birth registration and certificates also enable the tracing of children for social welfare purposes. Birth registration is therefore an instrument in social and economic planning. Given the importance, birth registration has risen to the top of the agenda in children's rights and wellbeing discourse.

Failure to provide birth certificates for these vulnerable children is a violation of their rights. Both the United Nations Convention on the Rights of the Child (CRC) (Article 7.1) and the African Charter on the Rights and Welfare of the Child (ACRWC) (Article 6.4) (OAU, 1990) stipulate that birth registration is a fundamental right and a child should be registered immediately after birth. A child has a right to a name and a nationality. Similarly, the SADC Minimum Package of Services for OVCs and the Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV/AIDS recognise that securing birth certificates is an essential service for OVCs.

While Zimbabwe's National Plan of Action (NPA) for OVCs is exemplary, it is the only one that explicitly recognises birth registration as a child's first human right (PEPFAR *et al.*, 2008), the country still has disturbingly high rates of unregistered births and a growing population of undocumented citizens. Thus, there is need for interventions to facilitate birth registration. Lessons can be drawn from birth registration and certificate interventions in Mozambique. The Accelerating Birth Registration programme in Mozambique employed a combination of a community-based model and a mobile registration that resulted in a sharp increase of registrations from 26% in 2006 to 70% in 2008 (UNICEF, 2008). The programme provided birth certificates for caregivers in order to facilitate birth certificates for the children (PEPFAR, 2007). For child-headed households however, it is particularly difficult as they do not have the required documentation and guardians to assist them with the process. Interventions should therefore take into consideration that children in child-headed households may not have the required documentation and to verify their identity, alternative strategies should be considered. This is

critical in protecting children's legal rights and will reduce the number of unregistered citizens in the country.

## **ii. Failure to Realise Education**

Children living in child-headed households fail to realise education as a result of multiple barriers. The realisation of education refers to making full use of access to education through enrolment, attendance and performance. Amidst their multiple challenges, missing and dropping out of school is one of the first effects children in child-headed households experience. In the current study, 51% of the survey participants including all seven participants from the qualitative inquiry phase were out of school. These findings are consistent with findings from a situation analysis, conducted across seven sub-Saharan African countries that showed just over 50% of children from child-headed households to be out of school (Lloyd and Blanc, 1996). In Uganda however, the number of child-headed households who were out of school was lower at 40% (Dalen *et al.*, 2009).

Education is a fundamental right for all children. This is enshrined in the United Nations Convention on the Rights of the Child (UNCRC) 1989 which states that primary and higher education including vocational education should be available and accessible to every child (Article 28). The World Declaration on Education for All (EFA) 1990 reaffirms this right. Failure to attend school has negative implications on children's quality of life (Belfield and Levin, 2007; Lasheras *et al.*, 2001). In particular, children are denied the life enhancing benefits that schools provide: a gateway to social services such as healthcare (immunisation); psychosocial care and support that builds resilience; food security through school feeding programmes; acquisition of livelihood skills; and socialisation that is often lacking in child-headed households.

Barriers to school enrolment, retention and performance for children living in child-headed households in the current study were a) lack of funds for school fees and school material; b) caregiving responsibilities; c) livelihood responsibilities; d) hunger; e) children not willing to return to school; and f) psychosocial distress. These barriers are also evident in other studies in sub-Saharan Africa that show high levels of absenteeism, dropouts and poor performance from



children living in child-headed households (Dalen *et al.*, 2009; Awino, 2010; Korevaar, 2009; Masondo, 2006).

*a. Lack of Funds*

Lack of funds is the most common factor in most impoverished households, which affects the enrolment and retention of children in school. Child-headed households have low or no income at all so attending school is often costly and out of reach for them. The costs of school attendance include actual costs, the school fees; hidden costs such as stationery, uniforms and transport; and opportunity costs such as livelihood and food production opportunities.

In the current study, lack of funds for school fees was the major factor contributing to drop out and failure to enrol. Children had to raise funds by engaging in numerous livelihood activities after school; most of them eventually dropped out as they failed to raise enough funds for themselves and their siblings. In most cases, the oldest sibling or the household head sacrificed his/her education and dropped out, in order to earn income to send his/her siblings to school. This self-sacrifice was a common coping strategy in many child-headed households. These findings are consistent with findings from a situation analysis of child-headed households in South Africa (Mogotlane *et al.*, 2010) where 82% of children were paying school fees for themselves and for their siblings. Older children dropped out of school to enable their siblings to attend school as they could not afford to pay fees for every child in the household. Other studies across Africa have also shown that lack of funds for school fees in child-headed households is a barrier to school attendance as some children dropped out. Others failed to write final examinations owing to the failure to raise school fees (Dalen *et al.*, 2009; Makame *et al.*, 2002; Delva *et al.*, 2009; Cluver and Gardner, 2007). In a study in Uganda where 40% of children were out of school, children indicated that they were chased away from school as a result of outstanding school fees; even when half the fees was paid by an NGO, children still failed to pay the remaining amount (Dalen *et al.*, 2009).

It is therefore evident that the lack of funds for school fees is a huge barrier to school enrolment and retention for children from child-headed households. These households are predominantly poor and constantly experience financial insecurity so without external support, school fees will

continue to be a barrier to accessing education. The irregularity of social protection measures, such as the BEAM programme that provided assistance with tuition fees, exacerbates these vulnerable children's plight. Like most fragile states, Zimbabwe's political turmoil and economic meltdown has resulted in reduced spending and massive budget cuts in social welfare (Murisa, 2010).

Introducing free primary education will go a long way to addressing this barrier to education, for child-headed households and many other vulnerable children. The impact of the implementation of free primary education on school enrolment is evident in several countries. In particular, Uganda, Tanzania and Kenya have made impressive strides in increasing enrolment through the provision of free primary education. Uganda was one of the first countries to implement free primary education in 1996 which led to a 70% increase in enrolment (UNICEF, 2009). Tanzania abolished school fees in 2001 and enrolment ballooned from 57% to 85% within the same year while Kenya had over 1.2 million children enrolled in schools after the introduction of free primary education (*ibid*). This massive ballooning of enrolment with the introduction of free primary education is indicative of how big a barrier school fees are.

Free education however, entails rapid and massive increase in enrolment, which requires additional resources such as teachers and infrastructure, which many African governments argue they cannot afford (UNESCO, 2016). Most countries are caught between human rights obligations and economic constraints (Tomasevski, 2005), and prefer to charge minimal user fees and subsidise. Nonetheless, the inadequacy of resources cannot justify failure to provide free primary education. As Tomasevski (2005) argues, the challenge is not the lack of financial resources rather a lack of political will.

Countries that cannot afford to provide free primary education should provide social protection measures for vulnerable children, which may include fee exemptions/waivers, cash transfers or fees assistance programmes. Zimbabwe has one such programme, the Basic Education Assistance Module (BEAM) that provides block grants to schools to cover all vulnerable children. However, this programme has not been successful in reaching children living in child-headed households, as evident in this study, where no participants were beneficiaries. The programme has lacked transparency, consistency, durability and predictability (Chitambara, 2010). Failure of this programme is largely a result of a lack of sustainable funding, as it is

largely donor funded, “political hijacking” and corruption in the selection process (The Zimbabwean, 2013; TARSC & ZIMTA, 2012). Such social protection measures require good governance and sustainable financing.

In addition to school fees, child-headed households are faced with other school related costs that inhibit them from attending school. These are considered as the *hidden costs* of education and include expenses such as uniforms, stationery, transport and food. These hidden costs are often out of reach for child-headed households and when they cannot afford these costs, they fail to enrol, often miss school and eventually drop out. Participants in the current study indicated that a contributing factor to dropping out of school was that they could not afford uniforms and stationery. This concurs with findings from a study in Bronkhorstspuit, South Africa (Masondo, 2006), where children from child-headed households dropped out of school because they could not afford textbooks, uniforms and other school material. Without the necessary resources such as textbooks and stationery, children’s performance may be affected. In addition, schools in the current study were far away, requiring the use of public transport, which children could not afford. They had to walk long distances to school and these long distances became a deterrent to going to school.

Hidden costs can be addressed through interventions such as state-funded stationery provision and school garden programmes that raise funds for stationery and uniforms for vulnerable learners. Interventions for opportunity costs may include livelihood projects or flexible learning that allows children to engage in their own income generating activities.

The predicament is that poverty is a barrier to education, which is a pathway out of poverty for these children and their households. Educational qualifications and skills equip children to improve their access to income and become economically empowered adults, providing an opportunity to escape the vicious intergenerational cycle of poverty. With increased income, households have better access to resources such as housing, water, sanitation, food and access to healthcare, so in the long-term, children who have attained educational qualifications, have the potential to have a better quality of life in adulthood. It is therefore critical to enable children to complete school in order to escape this vicious intergenerational cycle of poverty.

### *b. Caregiving Responsibilities*

Findings from the current study indicate that caregiving and household responsibilities affect school attendance amongst children living in child-headed households. With no adult support, children shared caregiving and household chores, with the oldest child taking up most of the responsibilities. Tasks included cooking, cleaning, fetching firewood, shopping and bathing siblings. These were demanding and did not leave room for school work. Children could not engage in both and as a result dropped out of school. One participant indicated that he dropped out of school in order to care for his siblings who were toddlers when the child-headed household was formed. This is in line with previous findings from South Africa; in the situation analysis, caregiving responsibilities were the second most cited reason for dropping out of school (Mogotlane *et al.*, 2010) In the Bronkhorstspuit study, household heads also dropped out to care for their siblings and attend to household responsibilities (Masondo, 2006).

Caregiving responsibilities are therefore a barrier to school attendance but they may also be addressed through school attendance. When all children in the household are in school, including the younger ones in nursery and childcare, older children have less caregiving responsibilities and are able to attend school. This also reduces children's vulnerability and exposure to risks and violent environments as they spend most of the day at school and less time at home. Interventions therefore to address caregiving responsibilities, should focus on enabling children to be in school, pre-school or care facilities depending on their age. Swaziland's Neighbourhood Care Point Programme provides a useful model. Neighbourhood Care Points (NCP) are community care centres that provide psychosocial support, daily meals, and education to young vulnerable children between the ages 4 to 12 years (UNICEF, 2009). The centres are run by caregivers, who are trained community volunteers and include young people, old women and men. Older children from child-headed households are able to drop off their young siblings while they attend school (*ibid*). This is an example of a community-based approach, where communities support vulnerable children reducing the caregiving burden of child-headed households.

c. *Livelihood Responsibilities*

Livelihood responsibilities for children living in child-headed households, particularly the household head, are a huge barrier to school attendance. In addition to being caregivers, children in child-headed households are the breadwinners for their households. For household survival, these children need to engage in some form of income generating activity which may compromise their education because they miss school and dropout. Children in child-headed households consequently experience conflict between the need to attend school and the need to engage in livelihood and food security activities (Daniel and Mathias, 2012). Ultimately, livelihoods, the immediate need, precede education, the long term need. In this study, all seven participants from the ethnography were out of school and engaging in some form of livelihood activity. One participant temporarily dropped out and returned and completed school after raising some funds, while another participant was operating a tuck-shop during the day and attending night school classes. This is consistent with findings from other studies (Nelson Mandela Children's Fund, 2001; Mogotlane *et al.*, 2010). In the Nelson Mandela Children's Fund (2001) study, orphans from child-headed households dropped out of school to earn income to support their siblings. Although most of these children received school fees and uniform support, they still needed income for food, clothing, toiletries and other basic materials. This further reiterates the point that providing school fees and school material is not enough to keep children in school.

Although children drop out of school to engage in livelihood activities, attending school actually empowers them to engage in a variety of livelihood activities as they learn essential livelihood skills such as agricultural and craftwork skills that they can apply immediately. In the current study, one participant used the agricultural skills he learnt from school to start a vegetable gardening project. This project generated income for his household, enabling him to clothe, feed and send his siblings to school. Another participant was able to get employment at a construction site using the skills he acquired from a building module he took at school. Accordingly, by accessing education, children in child-headed households are able to increase their income which can translate into improved quality of life.

d. *Hunger and Food Shortages*

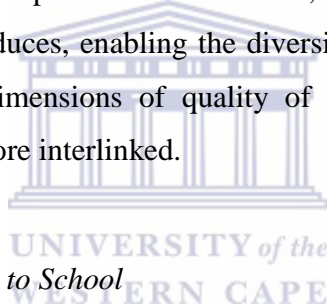
Children in the current study indicated that hunger and food shortages affected their attendance and performance in school, since they needed to source food and engage in food production activities. This is also evident in the Jimma Longitudinal Family Survey in Ethiopia where school absenteeism amongst adolescents was positively associated with household food insecurity (Belachew *et al.*, 2011). 51% of adolescents from households with severe food insecurity, missed school to engage in household work and income generating activities in order to put food on the table (*ibid*). The association between food security and school attendance has been well documented (Masset and Gelli, 2013; Jomaa *et al.*, 2011). As evidenced in this study, food insecurity at home increases the rate of absenteeism, as children miss school because of hunger and they cannot concentrate on empty stomachs. This is the premise of school feeding programmes, which aim to reduce hunger related absenteeism and increase concentration.

Furthermore, poor access to nutritious and sufficient food may result in malnutrition which can translate to poor health and increased morbidity (Behrman, 1996). In the Jimma Longitudinal study, food insecure adolescents had a higher frequency of illness compared to their food secure counterparts (Belachew *et al.*, 2011). Malnutrition affects children's cognitive and mental development and as a result they experience difficulty in concentration and performance. Increased morbidity also increases the frequency of absenteeism which negatively affects children's performance. As discussed in the literature review, malnourished children are likely to start school later and drop out compared to healthier children (Alderman, Hoddinott and Kinsey, 2003; Behrman, 2000; Behrman *et al.*, 2003; Glewwe, Jacoby and King, 2001; Grantham-McGregor *et al.*, 2007). This is evident in the Jimma survey where food insecure adolescents, after one year of follow up, had lower educational achievement compared to food secure adolescents (Belachew *et al.*, 2011).

When there is no food in the house, older children are pressured into leaving school to engage in food production and income generation activities to prevent their siblings from starving. In the face of severe food insecurity, attending school becomes a secondary issue and a luxury they cannot afford. Children in this current study sacrificed going to school in order to ensure household food security. Findings from the Jimma survey also showed that the proportion of

food insecure adolescents (24%) who completed primary education, was also lower than food secure adolescents (31.5%) (Belachew *et al.*, 2011).

As long as child-headed households experience food insecurity, their right to education will continue to be threatened. To increase school attendance and completion amongst children living in child-headed households, household food insecurity should also be addressed. In some instances however, simply attending school will address household and individual food insecurity. Most schools have school feeding programmes, where learners receive daily meals and take home food rations, thereby alleviating short-term hunger, improving household food security, nutrition and health, cognitive functioning and transferring income to families (Jomaa *et al.*, 2011). This is evident in Burkina Faso where food parcels from school feeding programmes resulted in improved nutrition of both learners and younger siblings at home (Masset and Gelli, 2013). When children receive food parcels to take home, their financial burden is eased, as household expenditure on food reduces, enabling the diversion of funds to other needs such as clothing and healthcare. Other dimensions of quality of life are thereby improved. Food insecurity and education are therefore interlinked.



*e. Children not Willing to Return to School*

An important consideration is the possibility that children may not be willing to return to school. There is the assumption that every child and adolescent wants to be in school which is the ideal but not the case. There are adolescents who dropped out early in school or never enrolled at all, who are now approaching adulthood and do not want to go back to school. Findings from the current study revealed that some adolescents are over age and feel too old to resume school as a result of late enrolment and temporarily withdraw from school. To return to class and learn with younger children can be daunting and embarrassing for children and adolescents. For example one participant, who had dropped out of school in grade four, was now 19 years old and did not want to go back to grade four at his age.



*f. Psychological Distress*

Another barrier to education for child-headed households is psychological distress which affects children's performance and as a result they drop out of school (Badcock-Walters, 2002; Bicego *et al.*, 2003; Mishra *et al.*, 2007). Literature indicates that this is a huge barrier to school attendance and performance for children living in child-headed households. However, this did not emerge as a barrier in the current study. Psychological distress may have been overarched by larger barriers discussed above. In this study, participants also showed high levels of psychological resilience, evidenced by high psychological scores in the quality of life survey. Psychological distress may therefore not have affected their education.

School attendance in itself helps safeguard against psychological distress in various ways. Firstly, teachers provide care and support through counselling and monitoring children's behaviour and material needs. They may be the only adults that children in child-headed households have regular contact with. School and teacher-based interventions have therefore the potential to serve as a platform, for nurturing children living in child-headed households and provide a framework through which care and support are made available.

Secondly, schools contribute to children's social integration and psychosocial development (UNICEF, 2004) by providing a platform for children to socialise and experience growing up with other children. This keeps children occupied, preventing them from thinking about their situation and challenges thereby reducing depression. Participants in the current study indicated that before dropping out of school, being with their peers enabled them to forget about their problems and was an opportunity to be a "normal" child.

Thirdly, for children living in child-headed households, schools can be critical in helping build resilience. Stone (2013) points out that, schools can help children develop the three building blocks of resilience - *I have, I am and I can*. Most schools provide a secure base where children feel a sense of belonging (*I have*) and through peer interaction and encouragement they develop good self-esteem (*I am*). Lastly, through explicit learning and curricula activities children develop a sense of self-efficacy with an understanding of personal strengths and limitations (*I can*) (Stone, 2013).

Importantly, socialisation takes place at school; with the family institution being incomplete in child-headed households, the school becomes the most important and influential agent of childhood socialisation. Socialisation is the process by which individuals learn norms and values of a given society or social group in order to function in it (Elkin and Handel, 1978). At school, children learn social skills, behavioural norms and values through interaction with peers, teachers and other staff. These norms and values are also reinforced in the classroom. Moreover, social control and social order, enforced at school exposes children to discipline which may otherwise be lacking at home; for example children learn that all actions have consequences.

Based on the above discussion, it is clear that this fundamental right is not being realised for most children living in child-headed households. It is also evident that school attendance has psychosocial, economic and health benefits for children living in child-headed households. There is growing recognition of their potential source of support for vulnerable children; they have often been referred to as “nodes of care and support”, “inclusive centres” and “healthy schools” (Khanare, 2012). Consequently to improve the quality of life in child-headed households, there is need for interventions that facilitate/enable school enrolment and retention.

### **iii. Food Insecurity**

Food insecurity is a huge challenge in impoverished households such as those headed by children. This section discusses the effects of food insecurity on children’s quality of life. In this study, most child-headed households experienced severe food insecurity. Some children went for days without meals and others depended on food donations from neighbours and well-wishers. Children indicated that food insecurity was their largest and most distressing challenge. These findings concur with the literature that indicates that food insecurity is the most urgent, critical and distressing challenge experienced by child-headed households (Masondo, 2006; UNICEF, 2009; Ibebuikwe *et al.*, 2014; Nelson Mandela Children’s Foundation, 2001; Tsegaye, 2008). In a study in South Africa, food insecurity was the biggest challenge experienced by child-headed households as many children in the study went for days without food (Nelson Mandela Children’s Foundation, 2001). This is also evident in a study in Ethiopia where child-headed households experienced low food quantities and often survived on discarded food (Tsegaye, 2008:22). A study in Congo also found that child-headed households had lower food security

compared to the general population (Roger, Fabrice and Aminata, 2006). This has far reaching implications on children's quality of life, as it translates to poor physical and psychological health outcomes; interrupts children's education; and increases children's vulnerability.

Coping strategies such as reduced meal size, meal frequency and reduced food quality can result in malnutrition thereby affecting children's cognitive and physical development (Awino, 2010; Belachew *et al.*, 2013). UNICEF's needs assessment of CHHs in Swaziland found that children's diets lacked essential nutrients such as fats and proteins (UNICEF, 2009). Consequently, malnourished children are more prone to illnesses and opportunistic infections (Katone and Katone-Apte, 2008; Hadley *et al.*, 2012; Tamiru *et al.*, 2016) and therefore experience a reduced quality of life. The current study did not measure the extent and nature of food insecurity, nor participants' nutritional status, as this was not within the scope of the study, however, participants indicated they felt that the lack of sufficient food affected their health and attributed their poor physical quality of life to food insecurity. Poor physical health also has repercussions on other aspects of children's quality of life. In particular, children's livelihood and food production activities may be affected. As a result of low education and limited skills, children from child-headed households often engage in labour-intensive livelihood activities which require energy and a healthy body.

Going to bed hungry and watching siblings going to school on empty stomachs was also distressing for children in the study. As a result, some household heads indicated that they would rather drop out of school to work in order to feed their siblings. It is therefore critical to address food insecurity as it has a direct impact on various aspects of children's wellbeing.

The effects of food insecurity on children's education include poor concentration and performance, increased absenteeism and high drop outs. When children are hungry they cannot concentrate in class and may miss school in the search for food and income. Respondents in this study indicated that household food insecurity prevented them from attending school as they needed to source food and engage in food production activities. In a study in Venezuela, higher incidences of food insecurity were associated with higher rates of school absenteeism as children who were more food insecure were absent from school for more days than food secure children (Diana *et al.*, 2005). Children eventually drop out of school to engage in food production as the need for food increases as discussed extensively in the education section.

Food insecurity in child-headed households in the current study was exacerbated by widespread food insecurity in Zimbabwe. The country's food shortages is a result of complex interlinked factors namely economic failure, recurrent droughts and famine and the disastrous land reform programme that reduced domestic agricultural production. As a result, there has been a massive decline in manufacturing and industrial production sector (Murisa, 2010) which in turn resulted in massive shortages of food products in supermarkets nationwide. This has turned Zimbabwe from Africa's bread basket to a food importing nation. According to the 2016/17 ZimVAC Rural Livelihood Assessment, 2.8 million Zimbabweans are in need of assistance in the first quarter of 2016 and this is estimated to go up to over 4 million in the first quarter of 2017. Consequently, the available food stuffs are exorbitantly priced which many child-headed households cannot afford, so child-headed households are experiencing lack of access to food.

In response to food insecurity, orphans in this study adopted creative coping strategies, including moving temporarily into another household and engaging in *humwe*, which is food for work. In the situation analysis in South Africa (Chiastolite study 2008), children reported receiving food from neighbours, friends and school feeding programmes. In Masondo's study (2006), children were begging for food while some relied on their friends' parents for food. Children ran errands for neighbours and community members in exchange for food and also relied on meals provided at school. However, with limited livelihood options and scarce resources, children struggle to put food on the table and may end up engaging in risky activities such as transactional and intergenerational sex and petty crimes.

Despite the severity of food insecurity in child-headed households, the need to ensure food security did not emerge as a critical theme in the validation workshop with stakeholders. Currently, no food security measures specifically targeting OVCs in Zimbabwe exist; stakeholders indicated that child-headed households receive food support under the Drought Relief Programme, which is only implemented in times of drought and famine. It is surprising that stakeholders viewed this intervention as sufficient for child-headed households. This programme cannot be counted as a social protection measure for child-headed households and other OVCs, as it is a seasonal strategy that is only implemented in: i) drought stricken areas and ii) in conditions of widespread drought and famine, which may be once in five years. It therefore does not address the perennial challenge of food insecurity in child-headed households.

The United Nations Convention on the Rights of the Child (UNCRC) states that all children, including those living in child-headed households are entitled to adequate nutritious food as a pathway to the highest attainable standard of health (Article 24). The International Covenant on Economic, Social and Cultural Rights (Article 11.2) also recognises the fundamental right of everyone to be free from hunger. In addition to attaining good health, food security in child-headed households enables children to use household income for other needs such as healthcare services, material needs – clothing, blankets, uniforms, and for school fees thereby increasing quality of life. It is therefore imperative to realise children’s right to adequate food.

The right to adequate food is realised when children have physical and economic access at all times to adequate food or means for its procurement (UN Committee on Economic, Social and Cultural Rights, 1999). This entails making food available, accessible and adequate. Food is made available from natural resources, markets and shops. Economic accessibility means food must be affordable and should not compromise other basic needs such as school fees while physical accessibility means food should be within reach. Adequacy refers to quantity, quality and appropriateness of the food; it must meet children’s dietary needs containing nutrients necessary for their physical and mental development. This entails creating an enabling environment for people to use their potential to produce food, or earn income to feed themselves in dignity and establish appropriate safety nets for those unable to do so (OHCHR and FAO, 2010). This places legal obligations on states to overcome hunger and malnutrition and realise food security for all (OHCHR and FAO, 2010).

#### **iv. Poor Housing, Water and Sanitation**

An individual’s living conditions are illustrative of his/her quality of life and standard of living (Mkhize, 2006). With limited financial resources many child-headed households lived in deplorable conditions. 57% of child-headed households were located in informal settlements characterised by poor quality housing, lacking electricity, clean running water, proper toilet facilities and solid waste disposal systems. These conditions have deleterious effects on children’s quality of life. It is therefore critical that this risk factor be addressed and prioritised for the explicit reason that an individual’s environmental surroundings are the largest

determinant of his/her quality of life (Pacione, 2003). This section unpacks the effects of these conditions on the various aspects of children's quality of life.

*a. Poor Housing Conditions*

The connection between housing and health are well established (Hood, 2005; Marais *et al.*, 2013; Evans, 2003). Housing is a major determinant of health and is a medium through which health determinants operate (Rourke *et al.*, 2012; Dunn *et al.*, 2006; Raphael, 2004). Housing is particularly instrumental in influencing children's quality of life, since they spend most of their time in and around the house (Marais *et al.*, 2013). This is where children sleep, wash, play and prepare food (Rourke *et al.*, 2012; Kothari, 2002). It represents the different physical, social, economic and cultural dimensions of a person's life (Chirisa, 2010). Housing conditions have therefore the potential to affect children's physical, psychological and environmental wellbeing.

Child-headed households often live in poor housing conditions, being self-reliant, with limited income and no adult support, (Amuge *et al.*, 2004). Housing conditions in the current study consisted of poor infrastructure, particularly regarding construction material and ventilation. Most child-headed households had brick housing structures and a few had tin and asbestos sheeting structures. The brick houses were mostly habitable, the tin and asbestos structures however, were concerning. Firstly, these structures expose children to temperature extremes; in winter children are exposed to extreme cold and in summer they are exposed to extreme heat, which the WHO (2016) indicates can lead to cardiac failure, stroke and respiratory infections. Secondly, indoor air quality is compromised by housing material such as asbestos. Asbestos in roofing and insulation has carcinogenic effects on inhabitants (WHO, 2016) and its use, in all forms has been banned in 52 countries (LaDou *et al.*, 2010). This finding is consistent with the existing literature that child-headed households live in dilapidated housing. In particular, a study in Uganda found over 30% of child-headed households living in very bad and dangerous conditions, with collapsed walls and leaking roofs (Dalen *et al.*, 2009). Most child-headed households do not have the resources or skills to maintain these homes (Sliep, 2003 *in* Mkhize, 2006).



Poor quality and unregulated housing often have poor ventilation (WHO, 2016), which has multiple health risks. The lack of adequate air flow increases moisture build-up, mould and bacterial growths, which poses a risk to children's respiratory health and may trigger allergies (*ibid*). Furthermore, poor ventilation can result in the accumulation of indoor pollutants. Thirdly, poor air circulation, increase the risks of transmitting airborne infectious disease such as tuberculosis. Some houses, including brick structures had cracks in roofs, floors and walls exposing the house to wind and water leakage during the rainy season. A similar finding emerged from a study conducted in South Africa that showed that orphans lived in houses with broken windows and doors, cracks on walls, mould and poor ventilation (Mkhize, 2006). These cracks can also result in pest and insect infestation, exposing children to various vector-borne diseases such as malaria and dengue fever (WHO, 2016).

The survey did not capture household electricity availability but based on the locations of the households, 63% did not have access to electricity. These figures are considerably higher than those of other orphans and vulnerable children living in adult-headed households. In particular, a study in Ethiopia found only 11.6% of orphans, were living in households with no electricity (Hamza, 2011).

In the current study, households used candles and paraffin lamps for lighting and firewood for cooking. Some children used home-made energy stoves made of saw-dust from industrial timber. For child-headed households this is particularly dangerous as they are unsupervised, with no adult having adequate knowledge of the handling of these fuels. Emissions from this saw-dust stove are released directly into the house and inhaled by children, which increase the risk of cardiovascular and respiratory diseases. The WHO (2016) notes that the indoor smoke generated from cooking and heating systems also increases the risk of childhood pneumonia, chronic obstructive pulmonary disease and lung cancers. Furthermore, the use of open fires and alternative fuels are associated with high risks of accidents such as burns, children falling into the fire and poisoning from ingestion (WHO, 2016).

In rural areas children had to spend time collecting firewood, which adds to their list of household chores. As a result, children have less time at school, to spend with friends, and to engage in livelihood activities. In some cases children have to leave younger siblings alone unattended while they forage for firewood.



*b. Poor Water and Sanitation Facilities*

Accompanying these poor housing structures was poor and in some cases non-existent sanitation facilities. Findings from the ethnography revealed that child-headed households lacked clean, safe drinking water, proper toilet structures and solid waste management systems, posing immense health risks thereby affecting their quality of life.

Access to safe drinking water is essential for human health and survival (WHO, 2014a). However, this is out of reach for many child-headed households. All households in the current study experienced water supply challenges in one way or another. 25% had running tap water, 46% sourced water from wells and boreholes while 28% sourced water from rivers. Households with tap water hardly had water owing to nationwide water load-shedding. In most municipalities water is available for 2 - 5 hours a day and sometimes municipalities go for weeks with no water (Human Rights Watch, 2013). During this period, child-headed households sourced water from community members with boreholes. In comparison with the Ethiopian study, child-headed households in this study were in far worse condition, as only 25% had access to tapped water compared to 78% of orphans in Ethiopia (Hamza, 2011).

Households that used wells, had either their own wells in their yard, used their neighbour's wells or made use of community wells and boreholes. The risk was in the handling and protection of these wells. Firstly, most wells were covered with asbestos sheets which are recognised as a health hazard (Mukonoweshuro, 2014) that causes asbestosis as well as lung, ovarian and gastrointestinal cancers (LaDou *et al.*, 2010; Burki, 2010). Secondly, some of the wells were not adequately protected/covered and were at risk of contamination from runoff during rainy seasons. Thirdly, the wells risk contamination from filled up latrines because of the close proximity between the two. This is largely a result of inadequate monitoring of adherence to the WHO and environmental health regulations, as communities erected their own pit latrines and wells. The WHO recommends construction of pit latrines downhill from water sources (WHO, 2014a). The safety of these water sources, are therefore questionable; hence about 74% of children in the study had no access to clean safe drinking water. This is considerably higher than findings from other studies; a needs assessment in Swaziland found 58% of child-headed households with no access to safe clean drinking water (UNICEF, 2009). The high figures in the

current study may be influenced by the context of a fragile state. Arising from exacerbated poverty, macro-economic failure and the state's inability to provide basic services to its citizens, the majority of Zimbabwean households have no access to safe drinking water. The state has been unable to maintain water treatment and upgrade the dilapidated water and sanitation infrastructure that dates back to the 1960s.

These settlements have no waste management services so residents dispose of domestic waste in refuse pits and open spaces (Mukonoweshuro, 2014). These open pits risk contaminating drinking water through leaching. Furthermore, these open pits are breeding grounds for water-borne diseases such as cholera and typhoid. During the rainy season, water collects in these pits providing breeding ground for malaria and dengue fever parasites. This is particularly concerning as these refuse pits were also playgrounds for very young children as observed during the ethnography.

Child-headed households had different toilet facilities. In formal high density settlements like Chegutu, households had flush toilets attached to the house while households in rural and informal settlements had traditional pit latrines separate from the house. Other households had their own pit latrine toilets while others shared with two or more households. Some households in rural settlements did not have any toilet facilities at all and made use of the bush and open spaces. This lack of toilet facilities for child-headed households in rural areas is not surprising considering that 40% of adult-headed households in rural Zimbabwe practice open defecation (UNICEF, 2014).

The challenges with the pit latrines were, firstly, they were located outside the house, with no electricity. In most of these communities it difficult for children to use these facilities at night, because of the security risk. Mukonoweshuro (2014) indicates that in such cases some households use plastic bags and buckets for ablution and dispose of them in the open refuse pits. Secondly, the latrines were located too close to the house and to water wells and without adequate bases they risk contaminating groundwater during seasonal high groundwater table.

Furthermore, based on observations and time spent with children, there was generally a lack of "handwashing after toilet use" culture amongst households in the study and the communities at large. This may be owing to water scarcity in communities.

This combination of poor sanitation, contaminated water supplies, poor drainage and overcrowded housing was a catalyst for the cholera outbreak in 2008/9 where over 4,000 people died (World Bank, 2012) and the more recent typhoid outbreak in 2010 (Brocklehurst *et al.*, 2013). Epworth and Hopley were the epicentres of these outbreaks. These appalling living conditions contribute towards children's overall quality of life and influence their physical health and psychological wellbeing.

#### **v. Failure to Access and Utilise Healthcare Services**

Failure to access and utilise healthcare services amongst children living in child-headed households in the current study was a significant factor affecting their quality of life. An individual's ability to access and utilise healthcare services is influenced by several factors which include income, education level and knowledge (Richter and Desmond 2008). For children in child-headed households, this is no different. Accessing healthcare services is vital for prevention of diseases, early detection and treatment of illnesses, and for maintaining good health. Health is a fundamental determinant of an individual's quality of life (Healthy People 2020, n.d.). For children living in child-headed households, who have multiple roles and responsibilities, accessing healthcare services is particularly important as their health inherently affects other functional capabilities that in turn determine their quality of life. A healthy child is able to concentrate in school, engage in livelihood and food production activities, and play with his/her siblings and peers, which all contribute to his/her quality of life and that of his/her siblings. It can be argued therefore that accessing healthcare services is one of, if not the most critical factors for ensuring good quality of life. The UNCRC recognises the right of every child to "the highest attainable standard of health and to facilities for the treatment of illnesses and rehabilitation of health" (UNCRC Article 24.1, 1989). Access to essential healthcare services is also recognised as a key strategic area in the Framework for the Protection, Care and Support of OVCs Living in a World with HIV/AIDS (UNICEF 2004).

In this study, barriers preventing children in child-headed households from accessing and utilising healthcare services were identified as a) poor knowledge on the importance of seeking healthcare; b) financial constraints; c) lack of required documentation; and d) conflicting responsibilities.

*a. Poor Knowledge*

Utilisation of health care services is inhibited by children's limited knowledge on health issues and of services available. Sibanda (2015) points out that delay in using primary health care services amongst children from child-headed households is associated with poor understanding of the gravity of their condition/illness. Firstly, these children are often not aware of health issues since they may have poor health literacy. This is as a result of the absence of an adult guardian and high rates of absenteeism and drop outs in school, where health education is taught. Consequently, children risk acute infections developing into chronic conditions. Poor health literacy amongst child-headed households has also been reported in Uganda (Amuge *et al.*, 2004 in Chiastolite, 2008) where child-headed households had limited knowledge of malaria signs and symptoms compared to adult-headed households. Secondly, children may not be aware of services available to them such as assistance in facilitating access and utilisation of healthcare services; in this study, children were not aware of the Assisted Medical Treatment Orders, which they can obtain to access health care services free of charge. Children's low educational levels and being out of school may be attributed to their poor knowledge of services available to them, concurring with Andersen's (1995) argument that poor educational levels inhibit access to health care services.

If children living in child-headed households do not consider being healthy as important in their hierarchy of needs, their utilisation of health services [when necessary] will remain limited. Maslow's theory of motivation indicates that higher needs such as health are only felt once the basic lower level needs such as food, water and shelter are met. Therefore to increase utilisation, health literacy in child-headed households needs to be increased along with addressing the needs that are ranked above health in these children's hierarchy.

Furthermore, strengthening community support as advocated by the Framework for the Protection, Care and Support of OVCs Living in a World with HIV/AIDS (2004) contributes towards increased awareness of health conditions and the utilisation of services in child-headed households. When children have guardians and mentors to monitor and advise them on health issues, they are likely to utilise health services when necessary.

### *b. Financial Constraints*

Lack of money for transport and clinic user fees prevented children in the study from utilising health care services. This concurs with Andersen's (1995) behavioural model of healthcare services utilisation that argues that individual socio-economic factors influence utilisation of health services. Even in instances where health services are available free of charge, facilities particularly in rural settings, may be too far and require use of public transport which many children in child-headed households cannot afford. This is also evident in Sibanda's study (2015) where children in child-headed households did not utilise health services, owing to the lack of money for transport and for hospital fees.

This financial barrier is exacerbated by Zimbabwe's economic collapse which resulted in the introduction of hospital and clinic user fees, widespread shortage of essential medical supplies spurring health facilities to request patients to supply their own drugs, gloves, water, candles amongst other supplies (Murisa, 2010). Consequently costs normally incurred by the health facilities have been shifted to patients, becoming a barrier to healthcare for child-headed households.

Elimination of user fees for vulnerable children such as those living in child-headed households will reduce the financial burden of utilising health services for child-headed households. Economic strengthening and food security interventions enable children to prioritise their health.

### *c. Lack of Documentation*

In addition, children from child-headed households do not utilise healthcare services because of the lack of appropriate documentation. In the current study, children indicated that they were often turned away from health centres because they did not have birth certificates or identity cards. As discussed earlier, many children living in child-headed households do not have identification documents such as birth certificates and identity cards so some children did not even bother going to healthcare facilities, because they knew this documentation was a prerequisite to accessing services.

#### *d. Conflicting Responsibilities*

Importantly, in cases where efforts to realise children's right to essential healthcare services are made, children living in child-headed households may not utilise these services because of conflicting responsibilities. From a child-headed households perspective, when health conditions are not life threatening, accessing healthcare services is often relegated. Household resources such as human, material, time and financial resources are often limited, yet household needs are numerous. A coping strategy therefore, is that the most immediate needs and responsibilities, critical for survival, such as financial and food security are prioritised and longer term needs such as seeking medical treatment are delayed or completely relinquished. For example, accessing health care services in public institutions often entails travelling long distances and waiting in long queues, which is time consuming. Children from child-headed households often do not have this time as they have numerous responsibilities such as caregiving, household chores, food production, income generation and attending school. Hours spent seeking healthcare translates to lost income which puts pressure on these households. As a result of these conflicting roles, children are forced to choose and logically, they will choose to meet their short term needs, those with the most immediate consequences such as income generation and food production, and will only attend to their health when their condition deteriorates and becomes urgent. This is evident in several studies (Francis-Chizororo, 2010; Meintjes *et al.*, 2010; Luzze and Ssedyabule, 2004; Phillips, 2011; Moffett, 2007; Maqoko and Dreyer, 2007). This is exacerbated by the absence of a responsible adult guardian to initiate and "push" children to seek these services.

Communities can also provide caregiving support to children in the form of looking after siblings as well as accompanying them to health facilities. This is evident in Sibanda's study (2015) where neighbours accompanied and synchronised their ART collection dates with those of children living in child-headed households. Linked to this is the need to bring health services closer to communities which may include increasing community health workers, mobile health services and increasing health facilities.

Other factors contributing to non-utilisation of health services by child-headed households, identified by Sibanda (2015), include long distances to health facilities, unreliable transport systems and negative attitudes of healthcare workers. Furthermore, it is the view of the

researcher that owing to the circumstances in child-headed households, these children have been exposed to various levels of emotional and physical strain. Some children have developed a high tolerance to pain and may take some illnesses lightly and delay seeking medical treatment.

### **8.2.2 Protective Factors for Child-headed Households**

The study also identified factors that positively impacted on children's quality of life. Protective factors are conditions or attributes in individuals, families, communities, or the larger society that, when present, mitigate or eliminate risk (Center for the study of Social Policy, 2008). Factors identified were children's social capital: siblings, peers and the community, and their agency. These were considered protective owing to their reliance enabling effect.

#### **i. Children's Social Capital**

The social capital available to children living in child-headed households in this study was a protective factor, enabling resilience against the multiple vulnerabilities they experienced. Social capital, which is the social psychological resources that children invest in and actively negotiate access to, when dealing with life circumstances (Skovdal and Ogutu, 2012), plays a critical role in the psychosocial wellbeing and development of children and adolescents affected by HIV/AIDS (*ibid*). In this study social capital consisted of siblings, community members and community childcare workers.

Four participants from the qualitative inquiry received support from their older siblings; this support included material, financial as well as psychosocial support. Children with older siblings that had moved out indicated that they often turned to their brother or sister for advice. Having someone to turn to in adversity creates a sense of security. Good relationship with, and support from siblings was also found to be a resilience enhancing factor in a study in South Africa where siblings were a significant source of support for children in child-headed households (Moffett, 2007).

The study demonstrated that the community plays a critical role in the wellbeing and overall quality of life of children living in child-headed households as community members provided



material and psychosocial support to adolescents. Community members provided children with food and water and regularly monitored their homes. Rural communities also engaged in the *Zunde raMambo* programme, which is an indigenous food security intervention that entails collective food production for vulnerable households, as discussed in the situation analysis. These findings support UNICEF's (2015) perspective that the community is best placed to care for its children; it is therefore vital that these communities are capacitated to enable them to continue supporting these vulnerable children. The UN Framework for supporting orphans and vulnerable children emphasises the critical role of community in its 5 strategies (UNICEF, 2004). It advocates for mobilising and supporting community-based responses; channelling resources to communities and social mobilisation to create a supportive environment for OVC. This approach entails empowering communities to support these children from within.

Community childcare workers in this study played a critical role in the lives of children living in child-headed households. As discussed in the situation analysis, community childcare workers are volunteers in the department of Child Welfare and Protection Services who identify, monitor and refer vulnerable children in their communities. These care workers visited child-headed households regularly and spent time with the children checking up on their wellbeing, indirectly playing a guardian role for these households. This resilient enhancing strategy/factor should be reinforced in order to improve quality of life in child-headed households. This approach has been applied in South Africa under the *Isibindi* programme, discussed earlier, where community workers support vulnerable households assisting children with household chores and homework.

Spirituality and religion also served as a protective factor for some children in the study and adolescents indicated that their faith in God gave them hope and a reason to live each day. This concurs with evidence from several studies show religiosity and spirituality to contribute to optimism during adversities such as war, natural disasters and during bereavement (Cotton *et al.*, 2005; Crawford *et al.*, 2006). In most religions, if not all, there is a higher power/supernatural being that provides unconditional love, which is important to children living in child-headed households who may feel neglected. Religion has consequently the potential to improve health and wellbeing for child-headed households, making this a crucial component to be considered in efforts to improve quality of life in child-headed households.

Involvement in religious activities also provides children and adolescents opportunities to socialise and establish social networks with peers and adult members. For example in this study, one participant temporarily moved in with a church member as a food security coping strategy. Belonging to a religious community also affords adolescents an opportunity to engage in various activities such as charity drives and outreach projects that can improve their personal development and leadership skills. The act of helping others may also provide healing to children.

Religion may also be instrumental in reducing negative and deviant behaviour amongst children and adolescents, as it provides a framework or guide for moral conduct. This framework is particularly important for child-headed households as they do not have parental and guardian support and upbringing.

However, support from relatives was evidently absent. This concurs with findings from other studies that reveal limited support from the extended family (Francis-Chizororo, 2008; Phillips, 2011). In such instances where extended family support is absent or limited, Daniel (2008) advocates for “created kin”, a type of “fictive kin”. Ebaugh and Curry (2000) define fictive kin as family-type relationships, based not on blood or marriage but rather on religious rituals or close friendship ties. Examples of fictive kin are godmothers and godfathers. In the case of created kin, a third party intentionally creates this relationship for the purpose of providing care and support where no kin are available.

Peer support, a significant form of social capital was also lacking in this study. Many participants reported that they lost contact with their friends when they dropped out of school hence reducing their social network. Furthermore, since becoming child-headed households participants indicated that they did not have time for play and leisure activities and also their interests became different from those of their school friends. This also resulted in them losing friends, and in some cases making new friends with similar concerns. These findings are consistent with existing literature that indicate that children leave friendships when they drop out of school (Skovdal and Ogutu, 2012; Dalen, Nakitende and Musisi, 2009; Yanagisawa, Poudel and Jimba, 2010).

In such circumstances where peer interaction is lacking, it is advisable to create platforms that enable this interaction. One well documented strategy is peer and youth clubs. This strategy has been employed across Africa for orphans and vulnerable children, of note are the youth clubs in

Kenya where caregiving children meet regularly to interact and engage in income generating activities (Skovdal, 2010). This is similar to a study in Rwanda where children from child-headed households received support from other children living in similar set ups. Peer support was crucial in building resilience in Evans study (2012). Peer clubs provide a form of bonding social capital, whereby children and adolescents meet others in similar circumstances with the potential of developing supportive and close friendships based on trust, reciprocity and a shared identity (Skovdal and Ogutu, 2012). Francis-Chizororo (2009) indicates that through networking, children from child-headed households can share their experiences providing emotional support to each other. This will provide children and adolescents with an opportunity for them to be like other children, establish friendships and escape from everyday responsibilities which is important in helping children deal with hardships (Skovdal and Ogutu, 2012).

## **ii. Children's Agency**

Children and adolescents found ways to deal with the situations confronting them, they adapted. Child heads, often the oldest became the caregiver making sure younger children had food, clothing and where possible attended school. With no breadwinner, children engaged in various activities to earn income. One participant engaged in vegetable gardening, growing tomatoes on a large scale as he lived in a rural area where land was abundant. Another participant opened a small tuck-shop in his neighbourhood selling groceries and toiletries. This tuck-shop provided income for food, clothing and school fees for himself and his siblings. These two examples reveal children's *agency* showing how they can adapt and rise above their adversities and thrive. Agency refers to the possibility of children acting within their context (Vigh, 2008, *in* Lee, 2012). Children are therefore not passive victims but are active agents and should be viewed in this light. These findings support the "new social studies of childhood" perspective that argues that children are social actors actively participating in their world as opposed to passively growing into it.

Children are often viewed as minors who are not capable of comprehending policy and development issues nor seeing the "bigger picture", however, this study, along with many others has shown that children and adolescents are able to comprehend, when explained to in simple terms and are social actors who not only are conscious of their situation but also know what they

want. As van Dijk (2008:261) points out that “if they are viewed as capable of running their own households, then they should also be perceived as able to make their own decisions”. They are therefore able to participate and contribute meaningfully towards developing interventions to improve their quality of life. Several studies attest to this (Evans, 2012; Lee, 2012).

There is much to learn from these resilient households therefore interventions should tap into the capacities and values that children have demonstrated (Ward and Eyber, 2009). These children should be empowered to have a voice in research and interventions involving and affecting them, they should not only be seen but they should be heard as well. This means that interventions should not only be child-focused but child-centred as well. If children are at the centre of interventions, this means taking their views into consideration as well as getting their participation in the development and implementation of interventions.

### **8.3 Summary**

This chapter discussed key themes that emerged from the study. Risk factors to children’s quality of life were failure to obtain birth certificates; failure to realise education; food insecurity; poor housing and sanitation; as well as failure to access health services. Cross-cutting influences to these risk factors were lack of funds, caregiving responsibilities and food insecurity. This discussion highlights the increased vulnerability of orphans living in child-headed households as a result of lack of adult support. Protective factors, namely children’s social capital and agency were also discussed. Based on this discussion, the next chapter presents recommendations for interventions to improve the quality of life in child-headed households.

## CHAPTER 9

### CONCLUSIONS AND RECOMMENDATIONS

#### 9.1 Introduction

This study set out to i) assess the quality of life of children living in child-headed households; and ii) explore protective and risk factors for these children. Another objective of the study was to develop guidelines for interventions to improve quality of life in child-headed households. This final chapter therefore, presents guidelines for consideration when developing interventions to support child-headed households. The guidelines are aimed at both state and non-state actors working with orphans and vulnerable children living in child-headed households.

#### 9.2 Limitations of the Study

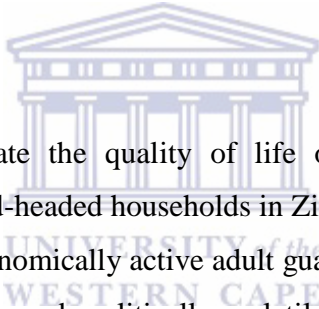
This study had two limitations which were methodological in nature: failure to obtain a larger sample size for the survey and failure to conduct an ethnographic study. A concern that may have limited the study findings is the small size of the survey. Children living in child-headed households were difficult to trace. Firstly, there was a dearth of information such as the population size, location and addresses of these households. In addition, children and adolescents living in these households are extremely mobile and constantly on the move away from home. They do not have mobile phones hence they are often referred to as an “invisible population” group (Earnshaw *et al.*, 2009). Furthermore, as a result of financial and time constraints, it was not possible to conduct a larger survey as finding these households would require extensive time and immersion in the field, employing snowball sampling. These were confounding factors that impacted on the survey size. Nonetheless, the survey size was sufficient to identify issues for exploration in the qualitative inquiry.

Furthermore, given the number of households and the time available, it was not possible to conduct strict ethnography in phase III, instead a qualitative inquiry using ethnographic

techniques was employed. Ethnography would have enabled the capturing the life stories of the children and how their quality of life changes over time. This requires a researcher to be immersed in the field for an extensive period of time and become a “native” in the community (Rose, 1997).

An additional confounding factor was that the researcher was unable to spend more time in child-headed households during the qualitative inquiry, because of a typhoid outbreak in the study areas. This resulted in the researcher falling ill and being quarantined. Nonetheless, the use of ethnographic techniques like participant observation, in-depth interviews and informal conversations provided a nuanced understanding of factors influencing quality of life in child-headed households.

### 9.3 Conclusions



This research sought to investigate the quality of life of orphans living in child-headed households. Children living in child-headed households in Zimbabwe are particularly vulnerable; in addition to the absence of an economically active adult guardian, these households are situated in a socio-economically unstable and politically volatile context. Zimbabwe’s precarious economic and political situation has resulted in widespread food insecurity, extreme poverty, and disintegration of health, education and social protection systems. This exacerbates the vulnerability of child-headed households. Using the determinants of health model and the quality of life conceptual framework and tool, the study identified factors influencing the quality of life in the fragile child-headed household. The factors are food insecurity, lack of birth certificates, the failure to realise education, the absence of adult guardians, social isolation and financial insecurity. Based on these findings this thesis makes the following conclusions:

#### **i. Children in Child-headed Households Experience Different Vulnerabilities**

Importantly, this study has shown that children living in child-headed households are often missed in social protection interventions that apply a blanket approach to all vulnerable children. Children are often unaware, unreachable and do not have the required documents to access social

protection. This thesis, therefore, argues that child-headed households are a unique group of vulnerable children that need interventions specifically designed for them.

This study makes an important contribution to the current discourse on child-headed households by presenting a holistic perspective of the quality of life in child-headed households. Previous studies have largely focused on one aspect of wellbeing, namely psychological wellbeing; this study adds to this body of literature by presenting the psychological, physical, social and environmental aspects of child-headed households. Detailed ethnographic accounts of the experiences of children living in child-headed households in Zimbabwe were used to do this. This holistic perspective of the quality of life, as well as the influencing factors, are significant in developing policies and designing programmes and interventions not only for children living in child-headed households but for other vulnerable children as well. These factors help inform the type of interventions to be implemented and contribute towards effectiveness of programmes.



## **ii. Social Environment Influences Quality of Life Perceptions**

A major theoretical implication of this study is the significance of social comparison in influencing children's perceptions of their wellbeing and quality of life. Life satisfaction amongst orphans was influenced by past experiences and was relative to the community that child-headed households were living in. Children and adolescents rated their quality of life in relation to other households and other children, thus experienced relative deprivation. This indicates the role of the social environment in influencing an individual's perception of his/her quality of life. Furthermore, the lack of exposure to other communities and lifestyles limited children's comparison or reference groups thereby limiting their aspirations. This confirms that perceptions of wellbeing and a "good life" are subject to an individual's awareness and encounters.

## **iii. Social Capital is Limited in Crisis Conditions**

This study demonstrates that social capital for orphans living in child-headed households is limited in conditions of socio-economic instability. In context of Zimbabwe's heightened



fragility, many households experienced unemployment, poverty, income and food insecurities, consequently reducing the support capability of children's social networks.

#### **iv. The Rights of Children Living in Child-headed Households are not Realised**

Based on empirical findings, this study concludes that the rights of children living in child-headed households are not realised. These include the right to education (Article 28); the highest standard of health and access to health services (Article 24); adequate standard of living (Article 27); as well as the right to acquire nationality (Article 7).

#### **v. Children in Child-headed Households are Active Agents**

The agency and resilience of children living in child-headed households is captured providing evidence that challenges notions of children as “helpless victims”. In response to their challenges, orphans in this study adopted creative coping strategies; some households went beyond coping and were thriving. This supports the “new social studies of childhood” perspective that argues that children are rational beings capable of shaping their own realities (Skovdal and Ogutu, 2012; Francis-Chizororo, 2008; Daniel and Mathias, 2012; Evans, 2005; Wood *et al.*, 2012; Lee, 2012).

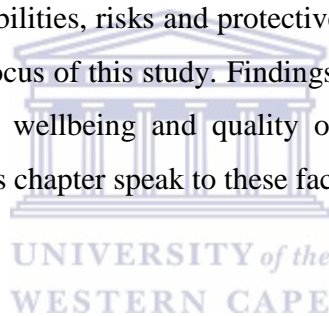
### **9.4 Guidelines and Recommendations**

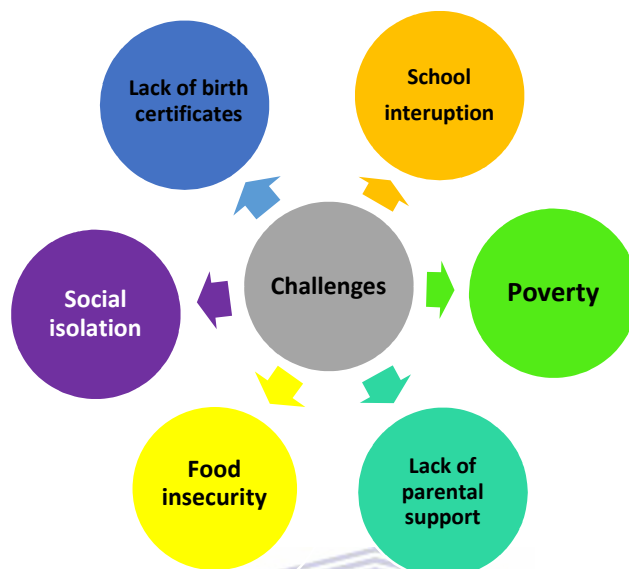
Findings from this study shed light on the experiences of orphans living in child-headed households in relation to their health, wellbeing and quality of life. These findings have been used to develop guidelines to address children's vulnerability and enhance their resilience so as to improve their quality of life. This section outlines these guidelines and recommendations. A guideline is a set of evidence-based recommendations on a specific topic (National Institute of Health and Care Excellence, 2014). The guidelines are for policymakers and programme implementers, working to improve the welfare of vulnerable children; furthermore the guidelines set out how stakeholders can work together in a complex environment to improve quality of life and wellbeing of children living in child-headed households.

The guidelines cover children, adolescents and youths from birth to 21 years of age, who are living in a household headed by a person below the age of 21, regardless of the presence or absence of an adult, that is both accompanied or unaccompanied child-headed households. The guidelines do not attempt to provide solutions to the challenges experienced by child-headed households nor are they prescriptive, rather they are suggestive and strictly recommendations to consider when developing interventions for child-headed households. Furthermore, the findings of this study, which are the basis of these guidelines, are context specific thus the recommendations proposed in this guideline should be seen in this light.

#### **9.4.1 Issues to be Addressed**

Prior to discussing recommendations and guidelines for child-headed households, it is essential to reiterate the challenges, vulnerabilities, risks and protective factors of children living in child-headed households, which is the focus of this study. Findings indicate that the following factors, presented in figure 9.1 influence wellbeing and quality of life in child-headed households. Recommendations presented in this chapter speak to these factors.





**Figure 9.1 Challenges of Child Headed Households to be addressed**



#### **9.4.2 Guidelines for Policymakers**

Findings from this study imply that there is a disconnection between policy and practice. The National Action Plan for OVC provides essential services to OVCs, yet many of these services do not reach children living in child-headed households. The study identified barriers preventing children in child-headed households from accessing these services as i) lack of required documentation, ii) no adult guardian and iii) the lack of information and awareness of services offered. To close this gap between services offered and those actually utilised by children living in child-headed households the following recommendations are made.

##### **i. Conduct a Survey and a Needs Assessment**

The study showed that there is need for up to date statistics on the magnitude of child-headed households in Zimbabwe. The first step therefore, in implementing an effective response in any context, is to obtain accurate statistics of child-headed households as well as identifying the

specific needs and factors influencing these needs. It is therefore imperative to conduct a national survey. The survey should be conducted and updated regularly and to facilitate this, an efficient information system needs to be in place. Documenting child-headed households will require children and adolescents to be registered and have some form of identity document, such as birth certificates and identity cards, so that they can be more accurately followed up. .

An information system will also facilitate information sharing across sectors. With readily available data, stakeholders are able to make better informed decisions. In terms of implementation, chances of duplication and “double dipping”, by beneficiaries, are reduced.

Knowledge of the unique vulnerabilities of children and adolescents, are key to the success of health and social support interventions (Toska *et al.*, 2016). Often, it is assumed that all child-headed households are vulnerable and experience the same challenges. This is however, not the case as this study has revealed; children’s vulnerabilities differ so a “one size fits all” approach will not work. Therefore, improved understanding of the needs of children living in child-headed households is necessary. A needs assessment will allow for a clearer understanding of the challenges and needs and thereby determine how best to support these children. This is particularly important given Zimbabwe’s volatile context. Furthermore, needs assessments contribute to planning and delivering the most effective care to those in greatest need (WHO, 2001).

## **ii. Facilitate Obtaining of Birth Certificates**

Documenting children and adolescents is a critical issue that needs to be prioritised. This will facilitate access to social protection. For this intervention, there is a need for collaboration between the department of Social Services and the Registrar General’s office. The Registrar General’s office should consider waiving its requirements for birth certificates for orphans living in child-headed households. As birth certificates and identity documents are an ongoing challenge for many vulnerable children in Zimbabwe, the Registrar General’s office should consider implementing a specific programme that facilitates obtaining these vital documents for all OVCs in the country.

### iii. Provide Alternative Education Options

Interventions for out-of-school children should consider alternative and flexible education approaches such as acceleration and catch up programmes. These programmes should be specifically designed for out-of-school children in their own class. One such example is the Second Chance Fit for Life programme, in Zimbabwe, that provides accelerated education modules with the aim of reintegrating out of school children back into the formal education system (TARSC and ZIMTA, 2012). However, caution should be taken when implementing these programmes in formal education institutions, as there is the potential that these classes may be labelled and stigmatised as classes for the “poor kids” or the “AIDS orphaned kids”.

Adolescents who are out of school can also be economically equipped and empowered through vocational training and life sustenance skills, since the right to education also entails the right to available and accessible technical and vocational education and training. An example is Rwanda’s Children’s Learning and Development programme (CHILD), that provides literacy and vocational training for older children, who dropped out of school or never attended formal schooling (UNICEF, 2009).

In keeping up with a holistic approach to enable child-headed households to realise their right to education, interventions should consider the household financial security dimension. Failure to take this into consideration may result in high levels of absenteeism and dropouts similar to the formal education system. Night schools and part time programmes offer flexibility for children to engage in both school and livelihood activities. The Complementary Basic Education in Tanzania (COBET) programme is one such intervention that provides both flexibility and equips children for their livelihoods (UNICEF, 2009). Out-of-school children are assisted to return to the formal education system through a condensed 3 year competency based curriculum (*ibid*). The programme is specifically designed to provide a combination of basic academic education and vocational skills. Furthermore, lessons are flexible allowing children to attend when they are available and they do not have to wear uniforms (*ibid*). The programme is currently operating in 21 regions in Tanzania and has been very effective in reducing absenteeism, lowering dropout rates and increasing performance/pass rates (*ibid*).

Furthermore, educational interventions should consider the psychological wellbeing of children living in child-headed households. This may include incorporating creative teaching pedagogies that enable vulnerable children to learn. For example, the Complementary Basic Education in Tanzania (COBET) programme applies participatory learning and teaching methodologies such as illustrations, role plays, dramas, storytelling and group discussions.

### **9.4.3 Guidelines for Programme Implementers**

The recommendations presented in this section are specifically targeted at programme implementers; these include, but are not limited to, state, non-governmental, community and faith-based based organisation actors, involved in designing and implementing interventions to support and improve wellbeing in child-headed households.

#### **i. Food Security**

Interventions may take the form of livelihoods projects, school feeding programmes, nutrition gardens, cash transfers and training children in agricultural skills and nutritional education. The Better Education and Life Opportunities through Networking and Organizational Growth (BELONG) programme in Zambia is an example of an education intervention that has a food security component. This programme aims to improve nutritional status, school performance and attendance by providing learners with breakfast and food parcels to take home (USAID and Catholic Relief Services, 2008). The project also has school gardens.

The Food and Agricultural Organisation (2008) points out, that improving long term food security, often requires a livelihood security approach. Training on agricultural skills, therefore has the potential to alleviate both short and long term food insecurity while providing economic livelihood security (UNICEF, 2009). This approach has been applied in Malawi through the “Junior Farmer Field and Life Schools” programme that trains vulnerable youths on agriculture and life skills, to ensure improved livelihoods and long-term food and nutrition security (FAO, 2010). This needs to be accompanied by resources, such as land and agricultural inputs, as some child-headed households do not have land and start-up capital.

Nutrition education should be a core component of food security interventions (IATT on Children and HIV, 2008) as food security also entails quality and nutritional value, so it is essential that children are taught about making healthy food choices.

Food security and nutrition interventions should strengthen households and communities to support these vulnerable households. The IATT Working Group on Food security, Nutrition, Children and HIV/AIDS advocates for family, household and community focused interventions (2008). Community gardens are an example of this community focused approach; these have the potential to improve nutrition in child-headed households and the community at large as children have access to healthier and more affordable food. The Food and Agriculture Organisation, World Food Programme and UNICEF have been successful in implementing community keyhole gardens, to support children affected by HIV/AIDS in Lesotho. This project recycles household waste water and harvests rainwater, is labour-saving and participants are taught how to preserve fruits and vegetables for consumption during dry seasons. This approach therefore addresses labour and water constraints, experienced by most child-headed households and ensures there is some food all year round.

However, community gardens alone are not sufficient to alleviate food insecurity. They need to be accompanied by other interventions. It is clear that food security is linked to economic security and education; thus, a multi-sectoral approach is required to implement a comprehensive intervention that addresses all facets of food insecurity. Similarly, the IATT Working Group on Food Security, Nutrition, Children and HIV/AIDS (IATT, 2008), stresses that food and nutrition interventions should be part of an integrated social protection package.

These strategies however, are context specific. Cash transfers for example, have the potential to improve food security as evidenced in Save the Children's cash transfer programme in Swaziland, that showed improved dietary diversity and food security (UNICEF, 2009). However, they require sustainable funding, so are not feasible for a fragile and cash-strapped country like Zimbabwe.



## ii. Engage the Community

The involvement of specific community groups is vital for the success of interventions. The community includes neighbours, religious and traditional society members and leaders such as pastors and chiefs as well as school teachers. Community participation is needed in both intervention design and implementation, as communities have the potential to provide valuable insight that may be otherwise overlooked by outsiders. By engaging communities, interventions will foster community participation, ownership and ensure sustainability (Schenk, 2009). It is particularly important to engage neighbours of child-headed households, as this will help reduce children's vulnerability to physical and sexual abuse and exploitation as they are better positioned to monitor these households. Community gate-keepers should be engaged to ensure "buy in" and community acceptability of interventions. In addition, engaging schools should be considered in community based interventions. These community groups can be engaged in various areas/domains such as agricultural/food security, economic and livelihood activities, child safety and protection, as well as psychosocial activities such as mentorships and social clubs. For example, in Tanzania's COBET programme discussed earlier, parents, caregivers, village vulnerable child committees, headmasters and education coordinators are responsible for the identification of learners to be enrolled in the programme.

Furthermore, indigenous community welfare systems should be strengthened; it is important to recognise and build on existing local strategies for the care and protection of vulnerable children. Many communities have local strategies to support child-headed households such as *Zunde raMambo*. Prior to implementing interventions therefore, it is critical that stakeholders explore existing strategies, and whether these can be complemented and strengthened and not duplicated.

In addition, religious and spiritual interventions are important as they have been shown to promote children's resilience. Thus an effective holistic approach should also consider spiritual interventions. However, great caution must be taken as religion should not be imposed as children must have a choice.

### iii. Adult Mentors

Implementing an adult mentorship programme may address the challenge of the absence of adult support and guidance in child-headed households. This may entail training local community volunteers to become mentors, who will conduct regular “informal” home visits and spend time with children and adolescents, to develop stable and caring relationships.

Adult mentorship provides a form of linking social capital which is “the interaction between people and networks across social strata and institutionalised power hierarchies with the aim of accessing support and leveraging resources” (Szreter and Woolcock, 2004 *in* Skovdal and Ogutu, 2012: 243). These adult mentors help provide guidance and advise children when necessary; they play a critical role of protecting and looking out for the best interest of these children and in addition to advising children, they can escalate issues to relevant authorities, for example property inheritance disputes. This assists children and youths to build positive relationships. The presence of an adult that children can talk to, has the potential to provide children with a sense of safety, thereby improving their psychosocial outcomes, as results from the Horizons intervention have shown (Schenk *et al.*, 2010).

Mentorship programmes have shown to be effective for vulnerable children as they have been applied in many different settings, for example the Auntes and Uncles program in Botswana that provides mentorship to vulnerable children and youth between 10 - 17 years. This may entail training local community volunteers to become mentors who will conduct regular “informal” home visits and spend time with children and adolescents to develop stable and caring relationships. This strategy was implemented in Uganda in the Horizons study (Schenk *et al.*, 2010) and in Rwanda’s CARE Nkundabana project, where community volunteers provide support to child and adolescent-headed households, such as assisting them to access social services. Another approach would be to use the existing Community Childcare Workers (CCWs) similar to the South African Isibindi programme, where CCWs assist children in child headed households with tasks such as preparing meals, getting ready for school, completing homework as well as assisting children to access social services (Thumbadoo, 2013). In Zimbabwe’s context however, this may not be feasible given CCWs’ high work load and the critical role they play in the Case management system.

It is however, critical that these mentors receive adequate support, in the form of training to equip them as effective and supportive mentors. In addition, mentors should be provided with psychosocial counselling, as they are likely to carry and share children's psychological distress.

**iv. Establish Community Centres**

Community centres that provide children with a range of services such as educational, vocational, psychosocial and material support should be established. These centres can serve as food security mechanisms for child-headed households, through implementation of community gardens that children are actively involved in, providing food for their households and selling extra produce to supplement household income.

The community centres can also provide day care services to enable older children to attend school and engage in livelihood activities. An example is Swaziland's Neighbourhood Care Point Programme; this programme is run by trained community members. Community centres will therefore also empower communities through skills training and employment creation.

**v. Encourage and Create Platforms for Peer Support**

To address the psychosocial wellbeing of children and adolescents living in child-headed households, it is beneficial to encourage and create platforms for peer interaction, as peer support plays an important role in the psychosocial wellbeing of vulnerable children and is associated with positive psychosocial outcomes (Ward and Eyber 2009; Thupayagale-Tshweneagae and Benedict, 2011). This may include interventions such as peer clubs or activities, where children get to meet other children and adolescents, who also live in child-headed households. As discussed in the previous chapter, peer interaction provides essential social capital for children living in child-headed households, providing an opportunity for children to escape from everyday responsibilities and experience a "normal childhood".

**vi. Recognise Children's Agency**

There is need for a move from the notion of children as helpless victims towards recognising children's agency in interventions for orphans living in child-headed households. Children and adolescents are rational beings, capable of making decisions about their lives. Programmes should recognise the social competencies of children and seek to understand how these children have reconstructed their realities; this will provide valuable insight on strategies that have worked for children. This entails applying a positive psychology paradigm that recognises and builds on existing positive strategies, promoting potential strengths to buffer children against adversity (Wood *et al.*, 2012). Furthermore, involving children and adolescents in the development of interventions will contribute towards acceptability and sustainability of interventions.



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## APPENDICES

### APPENDIX I: ETHICS CLEARANCE



OFFICE OF THE DEAN  
DEPARTMENT OF RESEARCH DEVELOPMENT

09 December 2012

#### To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and ethics of the following research project by:  
Ms KE Mmodawafa Chademana (School of Public Health)

Research Project: Quality of life in a fragile state: A study of orphans and vulnerable children in child-headed households in Zimbabwe

Registration no: 12/10/20

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

A handwritten signature in black ink, appearing to read 'Patricia Josias'.

Ms Patricia Josias  
Research Ethics Committee Officer  
University of the Western Cape

Private Bag X17, Bellville 7535, South Africa  
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A place of quality,  
a place to grow, from hope  
to action through knowledge

## APPENDIX II: Participant Information Sheet English



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### Participant information Sheet

**TITLE OF RESEARCH:** *Quality of Life in a Fragile State: A Study of Orphans and Vulnerable children (OVC) in Child-headed households in Zimbabwe*

Dear Participant,

You are being invited to take part in a research project. The research is being conducted for a doctoral thesis, which is a requirement for the Philosophiae in Public Health, which I am completing at the University of the Western Cape.

Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Please take your time to decide whether or not you wish to take part in this research.

My contact details and those of my supervisor are recorded at the end of this memo.

#### **PURPOSE OF THE STUDY**

This study proposes to assess and explore the quality of life of orphans in child-headed households and develop guidelines to improve the quality of life.

#### **DESCRIPTION OF THE STUDY AND YOUR INVOLVEMENT**

If you decide to participate in this study it will involve myself and three research assistants conducting a survey, an individual interview and possibly observation (following you in your daily activities) you and keeping a diary/ journal of thoughts and feelings. I will ask you about your life experiences relating to your health, community support, economic well-being and general problems.

During the interview and shadowing I will be taking notes of our discussion and will also use an audio tape recorder in order to adequately collect all the information that is needed for the study.

#### **CONFIDENTIALITY**

Your name will not be recorded during the interview so as to maintain confidentiality at all times. I shall keep all records and tapes of your participation, including a signed consent form which I will need from you should you agree to participate in this research study, locked away at all times and will destroy them after the research is completed.

### **VOLUNTARY PARTICIPATION AND WITHDRAWAL**

Your participation in this research is entirely voluntary i.e. you are free to decline participation. It is up to you to decide whether or not to take part. Refusal to take part will involve no penalty or loss of services to which you are otherwise entitled (as a client of the service) or, if you are a health worker, it will not impact negatively on your position as a staff member of this Centre.

If you do decide to take part you will be given this information sheet to keep (and be asked to sign a consent form). If you decide to take part you are still free to withdraw at any time - and without giving a reason. You may also choose not to answer particular questions that are asked in the study. If there is anything that you would prefer not to discuss, please feel free to say so.

### **BENEFITS AND COSTS**

You may not get any direct benefit from this study. While there are no immediate direct benefits to those participating in the study, the information we learn from you may help in improving the quality of life for you and other child-headed households. There are no costs for participating in this study other than the time you will spend in the survey and interview, which will last approximately 45 to 60 minutes. You will only be talked to within locality and thus you will not incur extra transport costs

### **INFORMED CONSENT**

Your signed consent to participate in this research study is required before I proceed to interview you. I have included the consent form with this information sheet so that you will be able to review the consent form and then decide whether you would like to participate in this study or not.

### **QUESTIONS**

Should you have further questions or wish to know more, I can be contacted as follows:

Student no: 3214441

Cell phone: +263 772 242986/ +27 737885688

Telephone at work: +27 219599370

I am accountable to:

#### **The Dean**

Professor Hester Klopper

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## APPENDIX III: Participant Information Sheet – Shona



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**Musoro wetsvanguridzo: *Quality of Life in a Fragile State: A Study of Orphans and Vulnerable children in Child-headed households in Zimbabwe***

**Nhare:**

### **Basa retsvangurudzo iyi**

Tsvakurudzo iyi ine chinangwa chekumusikidza uye kuongorora magariro nemararamiro enherera dzinogara dzega. Nzira itsva dzekudzikisa matambudziko aripo neachazovapo, evanha ava dzichaongororwa. Wakasarudzwa kuti ubvunzwe mutsvakurudzo ino nokuti unogara wega mu imba isina vanhu vakuru.



### **Zvaunofanira kuziva pamusoro petsvakurudzo iyi**

- Tinokupa gwaro rekubvuma iri kuti uverenge, uzive basa, matambudziko uye zvakanakira tsvagurudzo ino.
- Chinangwa chikuru chetsvagurudzo iyi ndechekuwana ruzivo rwekuti nherera dzinogara dzega dzino rarama sei, uye nezvinhu zvino simbisa nokudzikisa huraramo hwavo.
- Unokumbirwa kuti kuverenge uye kutarisisa gwaro rekubvuma iri zvakadzama. Bvunza mibvunzo yaunayo usati waita sarudzo.
- Mune kodzero yekuramba kubvunzwa uyewo mune kodzero zvekare yekubvuma kubvunzwa. Munekodzerowo zvekare yekuramba zvamunenge mambobvuma nekufamba kwenguva.

### **Zvichaitwa uye nguva ichatorwa**

Tinokumbira kubvunza mibvuzo yehupenyu nemararamiro enyu, mushure meizvozvo tinoda kuzogara nemi nokufamba nemi zvemazuva emwedzi mumwe chete. Chinangwa chekufamba nemi kwese kwamuchaenda ndochoku nzwisisa upenyu hwenyu tichi ongorora.

Mibvunzo:

- Munokumbirwa kuti mubvume kubvunzwa mutsvakurudzo iyi:
- Munogara muri vangani?
- Vabereki venyu vapenyu here?
- Mundy kangani pazuva?
- Munozviriritira sei?

### **Matambudziko uye kusagadzikana**

#### **Rubatsiro Rwamungawana**

Tsvangurudzo iyi ichabatsira vakuru venyika- vezveutano newe Welfare kuti vave nenzira dzokubatsira vana munharaunda. Zvichawanikwa patsvagurudzo iyi zvichabatsira vana vari munharaunda

#### **Zvakavanzika/ Tsindidzo**

Zvichawanikwa nezvatacha taura hazvisiri kuzoziviswa mumwe munhu kunze kwekunyorwa pabepa rechikoro rinoitwa doctoral thesis re Universiti yeWestern Cape ku Cape Town muSouth Africa. Mazita enya ha ahandiswe pakuchengeta zvichabuda, tmuchapiwa mazita matsa pa beba.

#### **Kuzvipira mukubvunzwa/ Bvumiro**

Kubvunzwa kuburikidza nekuzvipira, unokwanisa kubvuma kuti mubvunzwe. inzwai makasununguka kuzoramba kupfuurira mberi nekubvunzwa nguva ipi neipi zvayo uye hapana kubhadhariswa kwamunaitwa.

Kana muine mimwe mibvunzo kana zvamunoda kunzwisisa ndiwanika pa nhare:

Nhare: +263 772 242986/ +27 737885688

Vakuru vangu vanoitwa:

#### **The Dean**

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## APPENDIX IV: Child information Sheet



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**TITLE OF RESEARCH:** *Quality of Life in a Fragile State: A Study of Orphans and Vulnerable children (OVC) in Child-headed households in Zimbabwe*

Dear Participant,

You are being invited to take part in a research project. The research is being conducted for my studies at the University of the Western Cape.

Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Please take your time to decide whether or not you wish to take part in this research.

My contact details and those of my supervisor are recorded at the end of this memo.

### **PURPOSE OF THE STUDY**

My research will look at the quality of life of orphans in child-headed households and develop guidelines to improve the quality of life.

### **DESCRIPTION OF THE STUDY AND YOUR INVOLVEMENT**

If you decide to participate in this study it will involve myself and three research assistants conducting a survey, an individual interview and possibly following you in your daily activities and keeping a diary/ journal of thoughts and feelings. I will ask you about your life experiences relating to your health, community support, economic well-being and general problems.

During the interview I will be taking notes of our discussion and will also use an audio tape recorder.

### **CONFIDENTIALITY**

Your name will not be recorded during the interview so no one will know it is you. I shall keep all records and tapes of your participation, including a signed consent form which I will need

from you should you agree to participate in this research study, locked away at all times and will destroy them after the research is completed.

### **VOLUNTARY PARTICIPATION AND WITHDRAWAL**

Your participation in this research is entirely voluntary i.e. you are free to decline participation. It is up to you to decide whether or not to take part, there are no consequences for refusing to take part.

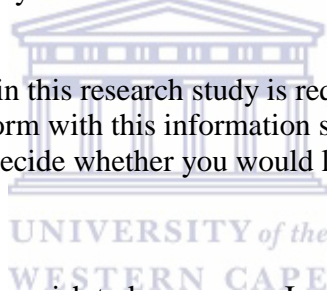
If you do decide to take part you will be given this information sheet to keep (and be asked to sign a consent form). If you decide to take part you are still free to withdraw at any time - and without giving a reason. You may also choose not to answer particular questions that are asked. If there is anything that you would prefer not to discuss, please feel free to say so.

### **BENEFITS AND COSTS**

There are no direct benefits from this study. While there are no immediate direct benefits, the information we learn from you may help in improving the quality of life for you and other child-headed households. There are no costs for participating in this study other than the time you will spend in the survey and interview, which will last approximately 45 to 60 minutes. You will only be talked to within locality and thus you will not incur extra transport costs

### **INFORMED CONSENT**

Your signed consent to participate in this research study is required before I proceed to interview you. I have included the consent form with this information sheet so that you will be able to review the consent form and then decide whether you would like to participate in this study or not.



### **QUESTIONS**

Should you have further questions or wish to know more, I can be contacted as follows:

Student no: 3214441

Cell phone: +263 772 242986/ +27 737885688

Telephone at work: +27 219599370

I am accountable to:

#### **The Dean**

Professor Hester Klopper

Faculty of Community and Health Sciences

University of the Western Cape, SOUTH AFRICA

Tel: +27 21 959 2631/2746 Fax: +27 21 959 2755

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#### **Supervisor**

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**APPENDIX V: Informed Consent Form**

**Title of Research Project:** *Quality of Life in a Fragile State: A Study of Orphans and Vulnerable children (OVC) in Child-headed households in Zimbabwe*

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered.

I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

**Participant's name**.....

**Participant's signature**.....

**Witness**.....

**Date**.....



## APPENDIX VI: Key informant interview guide

### Key Informant Interview Guide

---

#### Introduction to Key Informant

Tell me about your organization

How long have you been working with this organization?

What work do you do with child-headed households?

#### Theme: Child-headed households

1. Please give me your general overview of CHH in Zimbabwe
  - a. Why has the problem escalated to this point?
  - b. Social context that brings about CHH

#### Theme: Condition of CHH

3. What are the challenges/problems that CHH face?
4. Tell me about the wellbeing of these households (health, psychological issues)
5. From your perspective, how has the socio-economic hardship affected children from CHH?
6. Environment in which CHH operate in:
  - a. Do these children have access to services? (Easily able to get medical care, attend school?)
  - b. What is the condition of the houses CHH live in?
  - c. How safe are the neighbourhoods of the CHH you work with?

#### Theme: Coping Mechanisms of CHHs

7. What coping strategies have children adopted? (to deal with their challenges)

#### Theme: Forms of Support

8. What are communities doing to support CHH?
9. Do these children have extended families and relatives to support them in any way? How?
10. How is the department of Social Welfare and other Government departments assisting CHH?
11. Please tell me about policies and programmes in place to assist CHH:  
⇒ Probe on each policy/ programme

Where can I find more information and documents on these programmes?

12. What role are local NGOs playing:
  - a. Which NGOs are working with CHH?
  - b. What type of support are they giving CHH?
  - c. Do you know organizations/ people working with CHH that will be able to give me more information on CHH?

## **APPENDIX VII: Child and adolescent interview guide**

### **Demographic Information & Household characteristics**

1. How many brothers & sisters do you have?
  - 1b. What are their ages?
  - 1c. Do they all stay in the same house with you?
2. How many are you in this household?
  - 2b. How many adults & how many children?
  - 2c. Who is the head of the house?
3. How did you become a CHH?
  - 3b. Illness, medical costs, death, funeral, relatives, caregiving, effect of parental death,
  - 3c. How long have you been living alone (as children)?
  - 3d. How has your life changed since the passing away of your parents?
  - 3e. So do you see yourself as the parent now?
4. Who does the household chores?
5. Do you have a birth certificate, ID?

### **Domain 1: Economic Wellbeing**

6. Are you or anyone in this household working? (If so where, what, frequency eg daily etc)
7. What is the monthly estimated income?
8. Where do you find the food, clothing?
9. How do you pay school fees?

### **Domain 2: Social Support/ Relationships**

10. What assistance do you get from your relatives, NGOs, churches?
  - 10b. Describe the kind of support you get from the community.
11. What is your relationship with your relatives like?
12. Do you know of similar households in the community like yours?
13. How do you deal with a crisis in the household eg a sibling misbehaving

### **Domain 3: Environment**

14. What is the main source of drinking water for members of your household?
15. Does your household have electricity?

16. When you get sick, do you go to the clinic/ hospital?

**Domain 4: Physical Health**

17. Did you or your siblings suffer from any illness in the past month?

18. When was the last time you visited a hospital or clinic?

**Domain 5: Psychological Wellbeing**

19. Do you ever feel depressed? (tell me about it)

**Domain: Education**

20. Are you/ your siblings in school?

20b. Where do you learn? How far is the school?

**Domain: Food Security**

21. On average, how many meals per day do you consume?

22. What is the main source of food?

23. Do you ever experience food shortages?

23b. How has the household coped with food shortages?



**Challenges & Coping Strategies**

24. What challenges do you face as child-headed households?

25. How do you survive these challenges?

26. Of the challenges you have mentioned, what assistance do you get? (eg from NGO, Community, Gvt)

27. What type of assistance would you want to receive/do you need?

## APPENDIX VIII: WHOQOL-BY Psychometric Assessment Questionnaire

Quality of life assessment \_\_\_\_\_ ID #

What is your date of birth? Day \_\_\_\_\_ month \_\_\_\_\_ year \_\_\_\_\_

What is the current /highest education you have received? none primary secondary vocational

Are you currently at school? yes no If no, why? \_\_\_\_\_

Do you have a boy / girl friend? yes no don't tell

Are you currently healthy? yes no If no, why? \_\_\_\_\_

Name of referring organization: \_\_\_\_\_ Church denomination: \_\_\_\_\_

Father alive?            yes            no            don't know  
 Mother alive?        yes            no            don't know

I live with:

Parents            grandparents            younger sibling            older sibling            relatives

What age are your grandparents: \_\_\_\_\_

Is your grandparent healthy: yes            no

If no, what is the problem? \_\_\_\_\_

Ages and health status of other relatives living with you? \_\_\_\_\_

Is your guardian working? yes no

If yes, what?

Self employed            government            industry domestic            unemployed

Are you working?        yes        no

If yes, what and how many hours per week?

Less than 5            5-10            10-20            more than 20

Your monthly income average ZWD? \_\_\_\_\_

Have you good relations with your relatives? yes            no

If no, why?

Inheritance problem            lobola problem            other



The following questions relate to your life in the last 2 weeks.



F3.7	Do you get the kind of support from others that you need?	Not at all 1	Not much 2	Moderately 3	Good 4	Completely 5
G1	How would you rate your quality of life?	1 Very poor	2 Poor	3 Medium	4 Good	5 very good
G2	How satisfied are you with your life?	1 Very dissatisfied	2 Dissatisfied	3 Medium	4 Satisfied	5 very satisfied
F1.4	To what extent do you feel that physical pain prevents you from doing what you need to do?	Not at all 1	A little 2	A moderate amount 3	Very much 4	An extreme amount 5
F11.3	How much do you need any medical attention to function in daily life?	1	2	3	4	5
F4.1	How much do you enjoy life?	1	2	3	4	5
F24.2	To what extent do you feel your life to be meaningful?	1	2	3	4	5
F5.3	How well are you able to concentrate?	1	2	3	4	5
F16.1	How safe do you feel in your daily life?	1	2	3	4	5
F22.1	How healthy is your physical environment?	1	2	3	4	5
		Not at all	A little	Moderately	Mostly	Completely
F2.1	Do you have enough energy for everyday life?	1	2	3	4	5
F7.1	Are you able to accept your bodily appearance?	1	2	3	4	5
F18.1	Have you enough money to meet your needs?	1	2	3	4	5
F20.1	How available to you is the information that you need in your day to day life?	1	2	3	4	5
F21.1	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5
		Very poor	Poor	Neither poor nor good	Good	Very good
F9.1	How well are you able to get around	1	2	3	4	5
		Very dissatisfied	Dissatisfied	Medium	Satisfied	Very satisfied
F3.3	How satisfied are you with your sleep?	1	2	3	4	5
F10.3	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
F12.4	How satisfied are you with your capacity for work?	1	2	3	4	5
F6.3	How satisfied are you with yourself?	1	2	3	4	5
F13.3	How satisfied are you with your personal relationships?	1	2	3	4	5
F15.3	How satisfied are you with your sex life?	1	2	3	4	5
F14.4	How satisfied are you with the support you get from friends?	1	2	3	4	5
F17.3	How satisfied are you with the conditions of your living place?	1	2	3	4	5
F19.3	How satisfied are you with your access to health services?	1	2	3	4	5
F23.3	How satisfied are you with your transport situation?	1	2	3	4	5
		Never	Seldom	Quite often	Very often	Always
F8.1	How often do you have negative feelings such as bad mood, despair, anxiety and depression?	1	2	3	4	5

APPENDIX IX: POSTER 1 PRESENTED AT ICASA 2015 CONFERENCE

# Quality of Life of Orphans Living in Child-headed Households in Zimbabwe

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### Introduction

- Children living in child-headed households often experience multiple deprivations in the absence of an adult and economically active guardian.
- These deprivations range from income and material poverty to vulnerability to various forms of abuse which could reduce the quality of life of these children.
- This study assesses the quality of life of orphans living in child-headed households in Zimbabwe.

**Quality of life** encompasses "individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns". This includes individuals' physical health, psycho-social well-being and social relationships.

### Methods

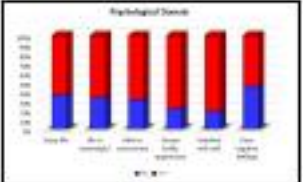
A quantitative survey approach:

- A psychometric survey was conducted between May - July 2015
- Sample: All identified (105) orphans living in child-headed households
- 8 sites in rural and urban Zimbabwe – Chegutu urban, Chegutu rural, Hopley, Epworth, Mbare, Highfield, Eyecourt & Stoneridge.
- World Health Organization Quality of Life BREF-Youth (WHOQOL-BY) Assessment tool was used
- Descriptive analysis using SPSS.

Domain	Sub-domain	Component
Psychological	Psychological well-being	Psychological well-being (positive and negative affect)
		Psychological well-being (positive and negative affect)
Physical health	Physical health	Physical health (physical health and disability)
		Physical health (physical health and disability)
Social	Social support	Social support (social support and social support)
		Social support (social support and social support)
Environment	Environment	Environment (environment and environment)
		Environment (environment and environment)
Overall QoL	Overall QoL	Overall QoL (overall QoL and overall QoL)
		Overall QoL (overall QoL and overall QoL)

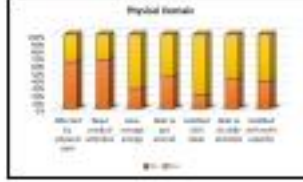
## Results

#### Psychological domain:



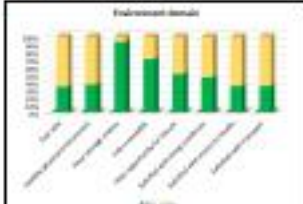
- There is a weak relationship (Pearson correlation 0.257) between psychological wellbeing and overall quality of life
- This implies that children's traumatic experiences have not significantly affected their psychological wellbeing indicating a high degree of resilience.

#### Physical domain:

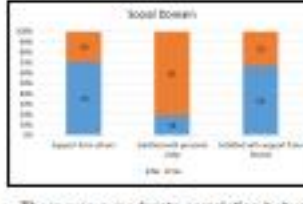


- Although majority were satisfied with their physical health, 33% needed medical attention to function daily.
- There was no significant correlation between physical health and overall QoL (correlation coefficient of 0.089).

#### Environmental domain:

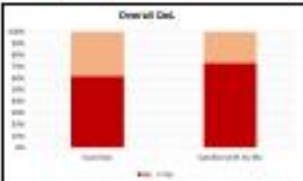


#### Social domain:



- There was a moderate correlation between social support and overall QoL (correlation of 0.484).

#### Overall quality of life:



### Conclusions



- Children responded positively to individual domain facets, but overall, they indicated not being satisfied with life and not having a good quality of life.
- The WHOQOL-BY's inability to capture factors contributing to children's dissatisfaction with their lives, indicates the tool's limitations in applicability particularly in settings with high levels of deprivation.
- Further research on the quality of life of children living in CHH is needed in order to obtain a more comprehensive understanding.

## APPENDIX X: POSTER 2 PRESENTED AT ICASA 2015 CONFERENCE

# Resilience of Orphans living in Child-headed Households in Zimbabwe

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<sup>2</sup> Sociology and Anthropology Department, University of the Western Cape

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### Introduction

- Although HIV prevalence in Zimbabwe has declined from 23.7% in 2001 to 16.7% in 2014, the country has a large number of orphans, an estimated 1 in 4 children is an orphan.
- This burgeoning orphan crisis coupled with intensifying poverty have diminished the ability of the extended family to look after orphans, and has led to the formation of new household structures – child-headed households (CHH).
- This study explored the challenges experienced by children living in child-headed households as well as their agency and resilience.

**Agency** is “the human capability to exert influence over one’s functioning and the course of events by one’s actions”


### Methods

- Phase II of a larger Quality of Life study: A qualitative inquiry using ethnographic methods.
- The study was conducted in 2 rural and 2 urban settings in Zimbabwe between May and July 2015.
- 7 orphans living in child-headed households were purposively selected from Phase I survey.
- In-depth interviews, informal interviews and observations were conducted.
- Thematic data analysis was conducted using Atlas.ti

**Resilience** is “the human capacity to face, overcome and be strengthened by or even transformed by, the adversities of life”.

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### Results



### Conclusions

- Children in CHH developed innovative coping strategies in response to their adversities, this reveals that they are active agents and not merely passive victims.
- Interventions should aim to build on the capacities of children and strengthen existing protective factors that allow children to exercise their agency thereby enhancing their resilience.
- At the same time, areas of vulnerability such as livelihoods and food insecurity, access to education and psychological distress should be addressed.

### References

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APPENDIX XI: POSTER 3 PRESENTED AT ICASA 2015 CONFERENCE

## Are Social Protection Mechanisms in Zimbabwe Adequately Addressing The Challenges Of Orphans Living In Child-headed Households?

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<sup>2</sup>Biological and Biotechnology Department, University of the Western Cape

### Introduction

- ❑ The number of child-headed households (CHH) in Zimbabwe is concerning. In 2010 more than 100,000 children were living in child-headed households.
- ❑ With no resident adult, these children experience higher levels of vulnerability compared to children living with adult guardians.
- ❑ Social protection programmes are aimed at reducing the economic and social vulnerability of poor, vulnerable and marginalised groups in a society.
- ❑ Zimbabwe has a range of social protection interventions for orphans and vulnerable children under the National Action Plan for OVCs

### Research question:

Are Social Protection mechanisms in Zimbabwe adequately addressing the vulnerabilities of children living in child-headed households?

### Methods

Mixed methods approach:

- ❑ 8 sites in rural and urban Zimbabwe
- ❑ Qualitative inquiry: in-depth interviews with 10 key stakeholders; interviews & observations with 7 children from CHH; document review of social protection policies and programme. Thematic analysis using Atlas.ti was conducted
- ❑ As part of a QoL survey, 105 children & youths living in child-headed households were asked whether they knew and/or were beneficiaries of 4 social protection interventions

### Results

Vulnerabilities of CHH	Social Protection Interventions Available
Food insecurity	• <b>Zimbe</b> (Zimbabwean) an indigenous social security strategy where the chief designates a piece of land that villagers cultivate and the harvest is stored in the chief's granary as reserve for drought, famine & for food insecure households.
Low household income/financial insecurity	• <b>Harmonised Social Cash Transfer Programme (HSCT)</b> : Cash transfer to impoverished households
Lack of school fees	• <b>Basic Education Assistance Module (BEAM)</b> : tuition fee, school levy and examination fee assistance is provided to vulnerable children. • <b>Second Chance Programme</b> : an accelerated learning program for out of school children, implemented through the Education Transition Fund
Cost of food health care services	• <b>AMTO</b> : fee waiver for treatment in public hospitals
Failure to obtain birth certificates & identity documents	No known support
Physical & sexual abuse	• <b>Child Protection Committees (CPC)</b> : Committees of community members, teachers, police and health-workers that ensure the protection and wellbeing of children in villages, urban neighbourhoods or communities
Psychological distress & depression	No known support

❑ 4 social protection interventions were identified – BEAM, AMTO, HSCT, and CPC. Children were asked whether they knew and/or were beneficiaries of these interventions:

Intervention	Know (n)	Beneficiaries (n)
BEAM	41	9
AMTO	9	2
HSCT	10	0
CPC	100	100

\* Sample was obtained from CPCs hence 100%

### Conclusion

- ❑ The vulnerabilities of children living in child-headed households are not being adequately addressed by existing social protection mechanisms due to (i) children's poor awareness of existing social services and (ii) lack of sufficient government funding which has resulted in the downscaling of services.
- ❑ Social protection interventions for OVCs need to be 'child-headed household sensitive' in design, targeting and selection.

Contact details: [www.cec@gmail.com](mailto:www.cec@gmail.com)

## APPENDIX XII: POSTER PRESENTED AT AIDS 2016 CONFERENCE

# Exploring Quality of Life of Orphans Living in Child-headed Households in Zimbabwe

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### Introduction

- One of the long term and far reaching effects of the HIV epidemic is the burgeoning orphan crisis.
- The combination of this orphan crisis and interloped poverty has eroded traditional safety nets as the extended family can no longer take in these orphans. This resulted in the formation of child-headed households.
- Over 100, 000 children live in child-headed households in Zimbabwe (UNICEF, 2010).
- In the absence of an adult and economically active guardian, these orphans are vulnerable to multiple deprivations which affect their quality of life.
- This study investigated the quality of life of orphans living in child-headed households in Zimbabwe.

**Quality of life encompasses "individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns". This includes individuals' physical health, psychological well-being, social relationships and physical environment.**

### Methods

**Phase I: Situation Analysis**

April - May 2013

- Purposive sampling of 30 key informants
- Content analysis & thematic analysis
- Thematic analysis in Atlas.ti

**Phase II: Opt Survey**

May 2013

- 5 sites in rural and urban Zimbabwe
- Inclusion sample of 80 children with identified CHHs
- WHO Quality of Life Survey
- Descriptive analysis in SPSS

**Phase III: Qualitative Inquiry**

June - July 2013

- Purposive sampling of 7 children selected from the survey
- Biographic Individualized Interview Schedule
- Thematic analysis in Atlas.ti

**Phase IV: Validation of findings**

February 2014

- Purposive sampling key stakeholders
- Workshop approach
- Thematic analysis in Atlas.ti

### Key Findings

**Setting**

- Modest informal settlements
- Poor housing
- No clean water & poor sanitation
- No electricity

**Coping Strategies**

- Construction work
- Leaving out rooms
- Operating a kioskship
- Food for work
- Private leisure

**Protective Factors**

- Supportive neighbours
- Belonging to religious institutions
- Having older siblings

**Social Protection**

- SP mechanisms available
- Education, Health care
- Orphan Transfer, Child Protection
- CHHs were not beneficiaries

**Risk Factors**

- Absence of adult guardian
- Income insecurity
- Lack of birth certificates

**Challenges**

- Food insecurity
- Material deprivation
- Failure to obtain birth certificates
- Conflicting responsibilities

#### Quality of Life Compounded Domain Scores

Domain	Positive responses (%)	Negative responses (%)
Physical	45	55
Psychological	45	55
Socioeconomic	45	55
Social relationships	45	55
Overall QoL	30	70

Domain	Composition
<b>Psychological</b>	Feelings about self, life, negative feelings and concentration ability
<b>Physical</b>	Experiences of physical pain interfering with life, energy, sleep and mobility
<b>Social relationships</b>	Satisfaction with support from family, friends & others
<b>Socioeconomic</b>	Feeling of safety and security, environment - pollution, aesthetics, noise, overcrowding, cleanliness and infrastructure; financial wellbeing; health services; transport; availability of information; recreational opportunities
<b>Overall QoL</b>	Self-rating of QoL and general satisfaction with life

- Quality of life in child-headed households is poor and is characterised by multiple material deprivation.
- Children from CHHs fall through the cracks as they are missed in interventions that target OVCs.
- Children's right to education, healthcare, housing and identity are severely compromised in CHHs.

- CHHs showed considerable resourcefulness and resilience as active agents and not passive victims.
- Interventions to support CHHs should look beyond children's vulnerabilities, and enhance protective factors and their agency.
- Adult mentorship and flexible alternative education are recommended.