

Factors leading to the establishment of child-headed households: the case of Zimbabwe

Geoff Foster, Choice Makufa, Roger Drew and Etta Kralovec

Family AIDS Caring Trust, Mutare, Zimbabwe



Abstract

This paper analyses factors associated with the establishment of 43 child- and adolescent-headed households in Manicaland, Zimbabwe. Such households result from the rapid increase in numbers of parental deaths leading to overburdening of the capacity of relatives to fulfil their traditional role of caring for orphans. Most children living in child and adolescent headed households have had both parents die in the preceding five years; many of them receive regular visits and support from relatives. Child-headed households represent a new coping mechanism in response to the impact of AIDS on communities. Community groups can help extended families to cope with the burden of orphans by encouraging the establishment of volunteer-based visiting programs to at-risk households and by channelling essential material support to destitute families.

The number of children being orphaned is rapidly increasing in communities with high rates of HIV infection; by mid-1996, it was estimated that nine million children had lost their mother to AIDS, with over 90 per cent of affected children living in sub-Saharan African countries (UNAIDS 1996). The epidemic is leading to a decreasing proportion of adults in the population and reduced incomes of affected households (Gregson et al. 1994; Leighton 1996:76). As a result of the impact of AIDS on communities, changes are taking place in caregiving arrangements for affected children (Foster et al. 1995); an increasing proportion of orphans are now in the care of the elderly and the very young (Foster et al. 1996; Saoko, Mutemi and Blair 1996:55). The emergence of households headed by children sometimes as young as 10-12 years old is one of the most distressing consequences of the epidemic.

The appearance of child-headed households in communities affected by AIDS is a recent phenomenon with cases noted in the late 1980s in the Rakai district of Uganda (WHO 1990; Alden, Salole and Williamson 1991) and Kagera region of Tanzania (Mukoyogo and Williams 1991). In 1991, such households were observed in Lusaka, Zambia (Ham 1992), Manicaland, Zimbabwe (Foster et al. 1995) and, for the first time, in six villages in the Masaka district of Uganda, where previously no such households had been noted (Naerland 1993). In the United States, cases of teenagers caring for younger siblings after deaths of parents from AIDS were reported in 1993/94 (Levine 1995:194).

In the Rakai district of Uganda, two per cent of orphans were living in households with a carer who was 18 years old or less and 97 per cent of orphan households had an adult of 17 years or more living in the household (UNICEF 1994; Nalugoda et al. 1997). Zambia and Uganda were estimated to have 3.8 and 2.4 per cent respectively of children under 15 years maternally orphaned by AIDS in 1995, increasing to 5.5 per cent and 3.5 per cent by the year 2000 (Michaels 1994). By 1996 in Zimbabwe, it was estimated that eight per cent of children under 15 years were motherless because of AIDS and this was projected to rise to 16-22 per cent by 2001 and 24-40 per cent by 2011 (Gregson et al. 1996).

It seems likely that once households headed by children start to appear in communities affected by AIDS, their numbers and relative proportion will both rise as the cumulative total of orphans continues to increase. Though it is often assumed that the presence of these households in communities implies that extended family methods of support have broken down, this assumption has not been validated since there have been no previous studies of

child-headed households. This study seeks to examine factors surrounding the establishment of such households, and the degree to which they are supported by relatives, and to explore reasons why relatives do not absorb orphans into their own families. Through better understanding of existing coping mechanisms, appropriate methods of support to children living in especially difficult circumstances may be developed.

The extended family and children

Traditional Zimbabwean Shona and Ndebele communities are built around a patrilineal kinship system. Members of the same patrilineage are grouped together, and the residential group is, or used to be, three to four generations. Traditional life is characterized by brotherhood, a sense of belonging to a large family and by groups rather than individuals. The extended family gives security and support and the members share many assets. Bourdillon (1991:26) writes:

It used to be, and still is, the ambition of a man to gather around him a growing lineage of descendants and dependants who would act as a corporate body for economic purposes and also a united body in times of crisis or tension within the community.

Traditionally, marriage used to be not so much the linking together of two individuals as of two families. When marriage was decided upon, a brideprice in the form of a number of cattle was paid to the bride's family; the payment of brideprice led to the children becoming the responsibility of the father and his family. Brideprice also created a special bond between brothers and sisters. The receipt of brideprice by a family for their daughter's marriage enabled them to pay the brideprice for their son. The son's children thus had a special link with their paternal aunt, who had a unique role in their upbringing. Traditionally, the concept of a 'social' orphan did not exist in Zimbabwean societies. Biologically orphaned children were cared for by members of their extended family, especially by aunts and uncles who took on the care-giving functions of parents. Under certain circumstances, other adults within the extended family besides the biological parents were called 'mother' and 'father' (Arvidson 1996).

The extended family was the traditional social security system and its members were responsible for the protection of the vulnerable, care for the poor and sick and the transmission of traditional social values and education. In recent years, changes such as labour migration, the cash economy, demographic change, formal education and Westernization have occurred and have weakened the extended family. Labour migration and urbanization have led to a reduction in the frequency of contact with relatives and encouraged social and economic dependence; possessions are perceived as personal property and no longer belong to the extended family. Increased life expectancy and family size mean it is now not possible for an extended family of three or four generations to reside together; the diminishing availability of land makes it difficult for large families to be economically independent through subsistence agriculture. Education about social values is likely to be obtained from schools and interactions of children with their peers rather than through traditional mechanisms, which has lessened the ability of older people to exert social control over the younger generation. Brideprice is nowadays often a cash payment earned by the husband-to-be, rather than cattle and other possessions raised by members of his extended family; thus marriage itself has become more a contract between two individuals leading to weaker links between and within extended families.

Some traditional roles of the extended family have been modified whilst others have almost disappeared. In Zimbabwe, brideprice is still commonly practised, though its nature has changed. The imposition of brideprice with high monetary value has led to unions being

established without the payment of brideprice, unrecognized by relatives from either family; such unions are inherently less stable and the children from them may be deemed not to belong to either extended family. Widow inheritance by a brother of the deceased husband is nowadays rare, though the traditional practice may have been replaced by brothers retaining sexual access to widows whilst not customarily inheriting and supporting them as second wives (Drew, Foster and Chitima 1996). The fact that orphans are now being fostered by maternal rather than paternal relatives, especially in peri-urban areas, is symptomatic of the decline of traditional extended family practices (Foster, Makufa and Drew 1995).

In spite of this, it should be emphasized that the extended family remains the predominant caring unit for sick relatives and orphans throughout Africa (Ankrah 1993). In the past, the sense of duty and responsibility of extended families towards other members was almost without limits. Even though a family did not have sufficient resources to care for existing members, orphaned children were taken in. This was the basis of the assertion that traditionally, 'there is no such thing as an orphan in Africa'. Even during the current crisis, and despite the appearance of child-headed households, most orphans are cared for by a member of the extended family. Extended family systems of caring for orphans are adapting to changes taking place within society (Foster, Makufa and Drew 1995). These changes illustrate the strength, resilience and adaptability of extended family coping mechanisms.

Methods

Background

The progression of the HIV epidemic in Zimbabwe has been rapid. Anonymous unlinked surveillance of pregnant women in five urban and 17 rural antenatal clinics during 1992/93 found 21.2 per cent (1205/5679) to be HIV-positive (Ministry of Health 1994). A 1992 enumeration study of orphans in Mutare district found 12.8 per cent of the children in the area studied were orphaned; 50 per cent of recent parental deaths were ascribed to AIDS (Foster et al. 1995). A 1995 enumeration in the area of the current study found 14.7 per cent of children orphaned with one quarter of parental deaths having occurred in the preceding year (Foster et al. 1996).

The Families, Orphans and Children Under Stress (FOCUS) program was established in 1993 by Family AIDS Caring Trust (FACT) in Mutare, Zimbabwe. The program is implemented by local churches in four rural areas of Manicaland province with a population of some 35,000 people; orphan households were identified by 88 volunteer women living in villages in program areas and those families most in need were given priority for regular visiting; during 1996, an average of 1398 supportive visits per month were made to 798 needy orphan households. In the city of Mutare, with a population of about 160,000, FACT supervises a church home care program using 30 volunteers with approximately 500 visits a month to some 200 clients and a FOCUS program with 10 volunteer visitors. FOCUS program records were reviewed and households headed by adolescents and children were noted; volunteer visitors identified additional child- and adolescent-headed households for inclusion in the study. A majority of orphan households were identified by one rural program assessed in 1995 and it is likely that a high proportion of households headed by children and adolescents were identified using local knowledge of rural community visitors (Foster et al. 1996). Much underreporting of such households in urban areas was likely since the orphan support program functioning in the city of Mutare was at an early stage in its development.

Definitions

A household is one or more people who share cooking and eating arrangements. The household head is the person primarily responsible for the day-to-day running of the household, including child care, breadwinning and household supervision; if tasks were shared, an attempt was made to determine the person primarily responsible for these tasks. A child is a person under 18 years old. An adolescent is normally defined as a person 13-24 years old; the definition used in this paper for adolescent-headed households is a household headed by a person 18-24 years old who is not the biological parent of children in the household.

The prevalence of child-headed households is still fairly low and some exist only temporarily. Adolescents may leave adolescent-headed households and such households as a result become child-headed. As child household heads reach 18 years old, their households by definition become adolescent-headed. Although this study focused on child-headed households, those headed by adolescents were also studied in view of the associations and similar situations of these two household types. Households headed by adults over 24 years were also studied if they had previously been child- or adolescent-headed. Where households contained adults with little or no responsibility for the day-to-day running of the household, including those with adult dependants who were sick, disabled or elderly, they were termed 'accompanied' child- and adolescent-headed households to distinguish them from households consisting of unaccompanied children and adolescents.

Although difficulties exist in household definition and classification, it was thought important to draw attention to the growing number of vulnerable, unaccompanied children living in especially difficult circumstances by using the terms 'child-' and 'adolescent-headed households'.

Survey instruments

A questionnaire was developed covering basic demographic and socio-economic information. Interviews were conducted in Shona and answers were written in English. Surveys were carried out during a four-week period from February 1997. The oldest available child or adolescent living in the household was interviewed by trained research assistants; occasionally, information was obtained from adults present in the households. Questionnaires were piloted with households outside the program areas and then modified. All households interviewed received material support in the form of food and some received payment of primary school fees for out-of-school children. Further focus-group discussions with household heads and in-depth family studies with other relatives were planned for a later phase of this research project.

Consent

Consent was obtained from respondents who were informed about the nature of the research, assured of confidentiality and given the option to decline to answer any or all of the survey questions. An attempt was made to identify a legal guardian and obtain informed consent for all households where minors were respondents.

Results

A total of 60 households were interviewed; 17 households were excluded because they were found to be headed by a grandparent, mother or aunt. In 43 child- and adolescent-headed households (including 27 child heads and 16 adolescent heads), there were 15 adults over 24 years, 23 adolescents aged 18-24 years and 146 children under 18 years, an average of 0.3 adults, 0.5 adolescents and 3.4 children per household; there were nine children under five

years old of whom three were children of adolescent household heads. The median age of respondents was 16 years (range 10-80 years). In six households, information was obtained from grandparents or aunts. The minimum prevalence of child-headed households in the four rural areas was four per thousand households.

Household classification

Of 43 households, 27 were unaccompanied households consisting of children or adolescents caring for younger children; three were unaccompanied single child or adolescent households; 13 were accompanied child-headed households or adolescent-headed households which contained 15 adults. Seven accompanied households contained grandparents who were too ill or debilitated (4) or blind and old (3) to supervise the households; one household also contained a mentally retarded mother; two households contained aunts, one who was too ill to care for children and one who was living in the same household but was not responsible for the daily supervision of orphaned children; five contained adults 25-29 years old, the spouses of two adolescent household heads, two step-brothers lodging with relatives and a 26-year-old female who had previously been the household's adolescent head.

Four adolescent-headed households were established previously when the household head was under 18 years. One child-headed household was previously headed by an adolescent who later left the household. In the month before the study, one household became adult-headed when children moved temporarily to their grandmother's home after their roof collapsed during a storm; and one became adult-headed after the child head ran away, followed by another sibling, leaving two younger children who moved in with an aunt.

Five households headed by adolescents and none by children were identified in the urban area. One urban household consisted of an adolescent who was left living alone after three younger siblings moved to a relative's rural home. The fact that no child-headed and few adolescent-headed households were identified in the urban area may indicate a low urban prevalence of these households. Living costs are higher in urban areas which leads some to relocate to rural areas where food, accommodation and education costs are lower. Children and adolescents living by themselves in urban areas may be evicted from their property for non-payment of rent or because they are exploited and have difficulty retaining their residence when accommodation is in great demand. There were anecdotal reports of urban child or adolescent-headed households breaking up, with boys becoming 'street kids' or leaving to work on rural farms and girls taking up low-paid domestic employment.

Orphanhood

Using a definition of orphans as children under 18 years who have lost either parent, 41 out of 43 (95%) households contained orphans. There were two non-orphan child-headed households: a single mother left home leaving a 16-year-old daughter looking after her younger sister; and a 14-year-old son looked after his mentally retarded mother, three younger children of different, unknown fathers and a blind, old grandmother. There were 44 orphan families since three orphan households contained children from two orphan families. In nine cases the whereabouts of at least one of the parents was not known. Both parents had died among 30 of 35 orphan families; in 18 double-orphan families, the father's death preceded the mother's; in three families, both parents died in the same year; and in eight families, the mother's death preceded the father's death. One case had no information on date of death. Most deaths were recent: 84 per cent of maternal and 74 per cent of paternal deaths occurred in 1993-1996.

Household formation

The household head was female in 25 cases and male in 18 cases. In 40 households containing younger children, the household head was an older sister in 25 cases; an older brother in 14 cases; and in one case an uncle. Children as young as 9 and 11 years old were responsible for looking after younger children and heading accompanied and unaccompanied households (Table 1). Seventy-five per cent of child and adolescent-headed households were established in 1995/1996, possibly reflecting an increasing incidence or the fact that many such households do not last long. Four households were established in the year before the mother's death when children or adolescents assumed headship during the mother's terminal illness. Most households were established in the same year as the last parental death, this being the mother's death in 80 per cent of households.

Table 1
Age of household heads, duration and timing of assumption of headship in 43 households

	Type of household (head)				All
	Child, unaccompanied	Child, accompanied	Adolescent		
N	17	10	16		43
Mean age at assumption of headship (years)	14.1	10.5	19.1		15.5
Mean duration of headship (years)	15.5	3.2	1.8		1.5
Assumed headship same year as parental death (N)	13	7	12		32
Assumed headship at least one year after parental death (N)	1	1	3		5
No data on timing, assumption of headship, or no orphans (N)	3	2	1		6

Reasons why current child or adolescent became the household head

In 21 orphan households, children or adolescents became household heads during the terminal illness or immediately following the death of a parent, this being the death of the mother in 15 cases and of the father in six cases (Table 2). One child assumed headship after the mother deserted. Twenty-one households had a total of 24 household heads other than the parent. Most of these caregivers lived with the children for less than a year before they left, became sick or died. Child or adolescent-headed households were established after illness or death of grandparents, aunts or an unrelated household head in 14 out of 43 households leading to nine unaccompanied and five accompanied households with, in the latter case, grandparents or aunts remaining and children or adolescents taking over household supervision.

Table 2
Reasons for change in headship by characteristics of the previous household head among 43 child and adolescent-headed households (CHH/AHH).

	Mother	Father	Grandparent	Sibling	Aunt	Other	Total
--	--------	--------	-------------	---------	------	-------	-------

Death or terminal illness	15	6	3	1	2	1	28
Illness or incapacitation	0	0	4	0	1	0	5
Left because of illness	0	0	3	0	0	0	3
Left for other reasons ^a	1	0	0	8	1	0	10
Total	16	6	10	9	4	1	46^b

^a Other reasons include employment, education, marriage; deserted; moved in temporarily; replaced by older household head.

^b Three CHH/AHH had two previous household heads.

Respondents were asked why relatives left children or adolescents living by themselves (Table 3). In 13 households, there was no known relative in the family able to care for the children. In one household, relatives left children alone because this was the mother's dying wish. In the remaining 29 households, a relative was available who might have been able to provide direct care for the children; but in 88 per cent of these households, the relative did not want to care for the children while in 32 per cent of households, the children did not want to move to the relative's household or the relative to move in with them. Relatives did not want to have the children living with them because the relatives had their own life to live, they had no space, they were in need of care themselves or they had no love for the children. In three cases, children did not move in with relatives because the children lived close to a relative who arranged to regularly visit them.

Table 3
Reasons why relatives left children or adolescents living by themselves (n=43, more than one response possible).

Reason	Number of responses
Relatives did not want children to move in with them	13
Relatives did not want to move in with children	11
Children did not want to move away from their home	8
Children wanted to stay together	3
Children did not want relative to move in with them	2
Mother's dying wish for children to stay by themselves together	1
No known relative	13
Not known or not answered	4

Extended family support

During the two years before the study, eight children under five years old, five children 5-9 years and four children 10-14 years left 13 households to stay with nine aunts, four grandparents, two sisters and one unspecified relative. One 14-year-old household head and his 13-year-old sister ran away from their household.

Sixteen households headed by children or adolescents received regular visits (more than once a month) by aunts (8), grandparents (2), sisters (1) or unspecified relatives (5); 11 received irregular visits (less than once a month) by relatives; three were known to have living relatives but received no visits from them. In those receiving irregular or no visits, relatives lived far away in 27 per cent of households. Relatives were unable to visit because they were too old in two cases. In the year before the study, 14 households received material support from relatives in the form of money (9), clothing (7), food (6) and school fees (5). Ten households known to have living relatives received no material support whilst there was no information on six households with living relatives.

Discussion

Although AIDS is only one of several factors leading to the changes being observed in traditional patterns of child care (Foster, Makufa and Drew 1995), it is undoubtedly the main factor predisposing to the establishment of child-or adolescent-headed households in this study. The AIDS epidemic is leading to a rapid increase in the number of double and maternal orphans. Previous studies have shown AIDS to be the underlying cause of most recent parental deaths in one area where this study was carried out (Foster et al. 1995). In a majority of these households, their establishment was associated with the second parental death which was usually that of the mother; 82 per cent of households contained children who had lost both mother and father and 89 per cent of parental deaths occurred in the preceding five years. In view of this characteristic pattern of parental deaths, it is likely that AIDS was the cause of death in a majority of study households. A number of other factors also predispose to the establishment of child-headed households: rapid increase in the number of parental deaths; death of one or both parents; reluctance of relatives to foster orphans; lack of contact of

relatives with children; death or sickness of a relative; presence of adolescents or older children able to care for younger children; preference of children to live in child-headed households; last wish of dying parent; death of single mother; and inheritance of residence by surviving children .

Uncles' and aunts' reluctance

There were 30 study households where a relative was known to be alive and in most (88%) of these households, it was stated that the relative did not want to care for the children. The preference of many parents should they be incapacitated is that their children be looked after by a same-generation relative such as an aunt or uncle (Foster et al. 1996). But many uncles and aunts are reluctant to foster relatives' children, possibly because of their concern that fostering relatives' orphans would result in a reduction of their own children's standard of living. If forced by economic circumstances to choose between their own and fostered children, they would tend to show preference towards the former. This course of action might lead to accusations against them of neglecting fostered children in their care by community members. Rather than risk such censure and in order to protect their own children, relatives may refuse to accept orphaned children into their family.

However, in 30 per cent of the households studied, relatives, mostly aunts, had taken at least one child from families in the study into their own households; most children under five years were fostered by relatives though older children were often not taken in. The main reason for refusal to take in relatives' children was probably economic. In many cases, aunts and uncles provided material support or regularly visited child-headed households; in some cases it was stated that relatives did not foster children in their own families because they lived nearby and instead had chosen to regularly visit. These are indications that in many cases, households headed by children or adolescents are a new expression of the extended family's coping mechanism rather than the result of children slipping through the extended-family safety net.

In some cases, relatives may consider themselves free of responsibilities towards orphans, even though they are closely related to the children. Relatives may not recognize the legitimacy of orphaned children, if, for example, a sister had children but was never married or if brideprice was never paid to her brothers; in such circumstances, they may feel justified in not providing support to her orphaned children after her death. Some relations have had little contact with a relative's family before the parent's death. A Kenyan study found that whereas families living below the poverty line tended to foster children, wealthier relatives, whom one might expect to be more able to foster relatives' children, maintained minimal links with orphans (Saoko et al. 1996:51). Some relatives may be concerned about fostering orphans when they suspect that the parent died from AIDS. They may fear contracting HIV infection from the children, or are afraid that bringing such children into their home may lead to stigmatization.

Distance and lack of knowledge of relatives about situation of children

There were 13 households in this study where respondents reported that they did not know any living relative. However the actual number of such households without living relatives is probably smaller, given the youth of the respondents in this survey. With families sometimes being separated by large distances, regular communication between family members may be difficult; as a result, close ties that formerly existed between family members have become weaker. Lack of assistance by relatives to child-headed households may be due to poor communication, with relatives simply not knowing about the desperate situations being faced by orphaned children living in difficult circumstances. Households which are separated by

large distances from their relatives such as migrant families and foreigners who have infrequent contact with their extended families are especially vulnerable in this regard (SafAIDS 1996). Barriers such as national borders make it especially difficult for extended families to fill their traditional roles of providing social support in times of difficulty.

Death or sickness of a relative

In this study, ten households were established following the death or illness of a grandparent and five followed death or illness of an aunt or unrelated household head. Three household heads who became ill moved out to be cared for by another relative while five continued living in the households.

When a parent, especially a mother, dies of AIDS, orphaned children often go to live with a grandmother, a practice referred to as 'skip-generation parenting' (Levine 1995:193). Orphans are often cared for by grandparents because there is no other relative willing or able to look after the children. Grandparent-headed orphan households are becoming increasingly common as a result of AIDS. In Zimbabwe, 125/292 orphan households (43%) were headed by grandparents; in Kenya, 41/152 (27%) were grandparent-headed whilst in New York, 25 out of 43 maternal orphans (58%) lived with a grandmother or an aunt (Foster et al. 1996; Saoke et al. 1996:55; Working Committee 1996:23). Grandparents are likely to be older and be more incapacitated than aunts and uncles. In Zimbabwe, 82/256 orphan caregivers (32%) were 60 years or older. During one year, in a population in Zimbabwe of some 11,000 people, three sibling-headed households became established following the death of a grandparent (Foster et al. 1996). Increasing numbers of child-headed households are likely to occur in the future through the death or sickness of relatives.

Adolescents learn child care during caregiver's illness

In four cases the households were established in the year before the last parental death. In such cases, households may be left by relatives to continue after the death of the parent because of the demonstrated ability of the adolescent to care for children appropriately during the parent's terminal illness. It is common for older children to take over parenting roles during prolonged parental illness due to AIDS. Adolescents learn responsibility, effective coping mechanisms and nurturing skills in this situation (Grodny 1994:140; Levine 1995:194). Were parents to die suddenly and unexpectedly, adolescents would have had no opportunity to take over care-giving responsibilities for younger children, forcing relatives to foster children. Similarly, if there were no adolescent caregivers in the household, relatives might feel forced to foster a relation's orphans.

Children's preferences and parent's dying wish

In this study, eight orphan families stated that they wanted to stay together and either declined to move to a relative's home or refused to have an unwelcome relative move in with them. In some cases, siblings in a family may choose to form child or adolescent-headed households. The children may desire to stay together as a family group rather than be split up between various relatives, or wish to stay living at their own residence in familiar surroundings, rather than change school, friends, home and neighbourhood. They may resist attempts of relatives to foster them in the relative's household, fearing maltreatment or because the relative only agrees to foster younger siblings. Orphaned children may be concerned about losing their inheritance rights to property and land if they are fostered. They may also be concerned about the possibility of neglect, abuse and exploitation by certain relatives. Urban children in particular may be concerned about their schooling being discontinued or a deterioration in

their standard of living should they be fostered by a poor rural relative. So instead, children may actively choose to stay living together in their own household rather than relocate to a poor, reluctant or abusive relative's home.

In one case, a child-headed household became established to fulfil promises made to a dying mother. Sometimes, adolescents have to make a deathbed promise to take care of young children and keep them together (Levine 1995:194; Foster et al. 1996). As a result of such promises, adolescents who might otherwise prefer to see the family fostered resist reasonable strategies for fostering suggested by relatives or child welfare authorities.

Death of a single mother

Child-headed households may be particularly likely to result from single-mother households. In this study, four such households resulted from the death of a single mother whose partner had left or deserted, and one resulted from a single mother leaving her teenage daughters to care for themselves. Increasing numbers of children in developing countries are being cared for in single-parent-headed households. In Zimbabwe, nearly one million children were born to divorced, widowed and never-married women (Central Statistical Office 1994). Some of the most vulnerable orphans are children of single mothers, especially if the mother was a prostitute. When a single mother becomes sick or dies, her children may be left in the care of grandparents. Because such orphans are from single-parent households, they may be neglected by other relatives who refuse to provide any support to the children because they consider them illegitimate.

Inheritance of residence by surviving children

The right of children to remain in their home after the death of their parents influences whether or not the family will continue to stay living together in their residence. In rural areas in Zimbabwe, the issue of land alienation by relatives seems not to be pronounced. However in a study of single-mother households in a rural area of Zimbabwe, whereas a majority of married and widowed women lived in their own accommodation, most divorced and never-married women rented accommodation or shared their house with relatives (Juliusdottir 1995); children of single mothers may be forced out of their accommodation after maternal death. In other African countries, the right of surviving children to continue living in their rural residence appears to be an important factor in determining whether child or adolescent-headed households become established. In urban areas in Zimbabwe where there is shortage of accommodation, it is difficult for children to hold on to their accommodation after parental death. Most people lived in rented accommodation in urban areas where this study was carried out. However, three out of five urban child-headed households lived in their own accommodation, suggesting that if children were living in rented accommodation before the parental death, it may be less likely for child-headed households to become established.

Conclusion

The new phenomenon of child-headed households appearing in communities affected by AIDS is an indication of saturation of traditional extended-family orphan coping mechanisms. Some communities may have better preservation of traditional coping mechanisms, such as those in remote rural areas with little urban migration and with lower life expectancy; the more traditional the community, the more capable it may be to cope with increasing numbers of orphans. Thus in an area of rural Mwanza, Tanzania, with an HIV prevalence of six per cent, eight per cent of children were orphaned but 32 per cent of non-orphaned children were fostered, not living with their biological parents, an indication that extended family coping

mechanisms were relatively intact; of 3353 households surveyed, only one child-headed household was identified (Urassa et al. 1997). High numbers of such households may indicate weakened traditional coping mechanisms or overwhelming of coping mechanisms by large numbers of orphaned children.

HIV prevalence rates in urban areas are higher than in rural areas in Zimbabwe. It is somewhat surprising that child-headed households in this study appeared to be less prevalent than in rural areas, notwithstanding differences in sampling methodology. In urban areas, a combination of social and economic factors hinders the establishment of such households. Prospective studies of households with risk factors predisposing to their being headed by children or adolescents might clarify whether child-headed households are being established in urban areas following parental death and the ways in which such households terminate.

When these households first occur in communities, they may be transient. Families take time to organize coping strategies in response to unaccompanied children. Child-headed households may disintegrate when children integrate into a relative's household, sometimes after a crisis when relatives who were previously equivocal agree to take in the children. Projections for Zimbabwe suggest that the current high orphan incidence rate of 2-3 per cent per annum has occurred since the early 1990s and is likely to continue until at least 2010 (Gregson et al. 1997). As the numbers of orphaned children multiply, it is likely that there will be increasing numbers of child-headed households; they will become less transient, existing for longer periods; and household heads will be younger.

The appearance of child-headed households does not necessarily mean that extended families are abandoning their responsibility to care for relatives' children. This study demonstrates that among households with known relatives, most were receiving regular supportive visits and small amounts of material support from their extended family. In some cases, members of the extended family refused to take unaccompanied children into their households because they knew that a relative was living nearby who could provide support and supervision. A number of orphans were taken into a relative's household where they were being cared for, especially when the children were under five. In a minority of child-headed households it seemed that extended-family methods of support had broken down since such children received little or no support from relatives and appeared to be particularly vulnerable to exploitation as a result of destitution and lack of adult supervision. The numbers of such unsupported households are likely to increase dramatically in the future in the face of poverty as the number of new orphans increases and as grandparent-caregivers or aunts and uncles become sick and die.

Households headed by children or adolescents thus represent a new coping mechanism in response to the impact of AIDS on communities. Where these households exist, there are often relatives living nearby who are providing material support, supervision and regular visits; such relatives are often also struggling to bring up their own families. Community groups can help extended families to cope with the burden of orphans and prevent the breakdown of the extended-family safety net by encouraging the establishment of volunteer-based visiting programs to at-risk families, and by channelling essential material support to destitute families (Foster et al. 1997).

References

- Alden, J.S., G.M. Salole and J. Williamson. 1991. Managing Uganda's orphan crisis. Kampala: Technologies for Primary Health Care (PRITECH) Project.
- Ankrah, E.M. 1993. The impact of HIV/AIDS on the family and other significant relationships: the African clan revisited. *AIDS Care* 5:5-22

- Arvidson, M. 1996. Caring for children: orphans in the AIDS-affected in Zimbabwe. Program on Population and Development, Report No. 13. Lund, Sweden: University of Lund.
- Bourdillon, M.F.C. 1991. *The Shona Peoples*. Gweru, Zimbabwe: Mambo Press.
- Central Statistical Office. 1994. *National Report*. Harare.
- Drew, R.S., G. Foster and J. Chitima. 1996. Cultural practices of orphaned families in the north Nyanga district of Zimbabwe. *Journal of Social Development in Africa* 11:79-86.
- Foster, G., C. Makufa and R. Drew. 1995. Am I my brother's keeper? Orphans, AIDS and the extended family's choice of caregiver. *Sociétés d'Afrique and SIDA Newsletter*, October. Bordeaux.
- Foster, G., C. Makufa, R. Drew, S. Kambeu and K. Saurombe. 1996. Supporting children in need through a community-based orphan visiting program. *AIDS Care* 8:389-403.
- Foster, G., C. Makufa, R. Drew, S. Mashumba and S. Kambeu. 1997. Perceptions of children and community members concerning the circumstances of orphans in rural Zimbabwe. *AIDS Care* 9: 393-407.
- Foster, G., R. Shakespeare, F. Chinemana, C. Makufa and R. Drew. 1995. Orphan prevalence and extended family care in a peri-urban community in Zimbabwe. *AIDS Care* 7:3-17.
- Gregson, S., G.P. Garnett, R. Shakespeare, G. Foster and R. Anderson. 1994. Determinants of the demographic impact of HIV-1 in sub-Saharan Africa: the effect of a shorter mean adult incubation period on trends in orphanhood. Pp. 65-92 in *AIDS Impact and Prevention in the Developing World: Demographic and Social Science Perspectives*, ed. J. Cleland and P. Way. Supplement to *Health Transition Review* 4. Canberra: Australian National University.
- Gregson, S., B. Zaba, G. Garnett and R. Anderson. 1997. Projecting the HIV/AIDS epidemic in southern Africa. Paper presented at IUSSP/University of Durban Conference on the Socio-demographic Impact of AIDS in Africa, 3-6 February, Durban.
- Gregson, S., T. Zhuwau, R.M. Anderson and S. Chandiwana. 1996. *The Early Socio-demographic Impact of the HIV-1 Epidemic in Rural Zimbabwe*. Harare: Blair Research Institute.
- Grodny, D. 1994. Programs for children and adolescents. In *AIDS and the New Orphans*, ed. B. O. Dane and C. Levine. Westport: Auburn House.
- Ham, M. 1992. Children learning to be strong. *Africa South Magazine*, June:40-41.
- Juliusdottir, M. 1995. Female-headed households in Zimbabwe: demographic characteristics and livelihood strategies. Program on Population and Development, Report No. 9. Lund: University of Lund.
- Leighton, C. 1996. The direct and indirect costs of HIV/AIDS. Pp. 65-87 in *AIDS in Kenya: Socioeconomic Impact and Policy Implications*, ed. S. Forsythe and B. Rau. Arlington: Family Health International/AIDSCAP.
- Levine, C. 1995. Today's challenges, tomorrow's dilemmas. In *Forgotten Children of the AIDS Epidemic*, ed. S. Geballe, J. Gruendel and W. Andiman. New Haven: Yale University Press.
- Michaels, D. 1994. Projections of motherless AIDS orphans under 15 in six countries. In *Action for Children Affected by AIDS - Programme Profiles and Lessons Learned*. New York: World Health Organization/UNICEF.
- Ministry of Health and Child Welfare. 1994. *Report of an HIV / STD and AIDS Surveillance Workshop, 7-8 July, 1994*. Harare.
- Mukoyogo, M.C. and G. Williams. 1991. AIDS orphans, a community perspective from Tanzania. Strategies for Hope No. 5. London: Action Aid/AMREF/World in Need.
- Naerland, V. 1993. AIDS-Learning to be more helpful. Kampala: Redd Barna.

- Nalugoda, F., M.J. Wawer, J.K Konde-Lule, R. Menon, R. H. Gray, D. Serwadda, N. K. Sewankambo and C. Li. 1997. HIV infection in rural households, Rakai District, Uganda. This volume.
- SafAIDS. 1996. Orphans on farms: who cares? An exploratory study into foster care for orphaned children on commercial farms in Zimbabwe. Harare: Southern Africa AIDS Information Dissemination Service.
- Saoko, P., R. Mutemi and C. Blair. 1996. Another song begins: children orphaned by AIDS. Pp. 45-64 in *AIDS in Kenya: Socioeconomic Impact and Policy Implications*, ed. S. Forsythe and B. Rau. Arlington: Family Health International/ AIDSCAP.
- UNAIDS. 1996. UNAIDS and UNICEF launch the 'Children in a World with AIDS' Initiative. Factsheet. 28 August. Stockholm.
- UNICEF. 1994. *Action for Children Affected by AIDS - Programme Profiles and Lessons Learned*. New York: World Health Organization/UNICEF.
- Urassa, M., J.T. Boerma, J. Z. L. Ng'weshemi, R. Isingo, D. Schapink and Y. Kumogola. 1997. Orphanhood, child fostering and the AIDS epidemic in rural Tanzania. This volume.
- World Health Organization (WHO). 1990. Draft discussion paper on the care and support of children of HIV infected parents. 14 September. Geneva.
- Working Committee on HIV, Children and Families. 1996. *Families in Crisis*. New York: Federation of Protestant Welfare Agencies.