Orphanhood, childhood and identity dilemma of child headed households in rural Zimbabwe in the context of HIV/AIDS pandemic

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Abstract: This paper focuses on orphaned children who have lost both parents and currently living on their own as child headed households (CHHs), in a rural community in Zimbabwe. The paper examines how Zimbabwe's escalating HIV crisis has reconstructed childhood through an exploration of how CHHs evolved, the socialisation of household members, gender roles and survival strategies. This paper draws on an intensive ethnographic research project with five child heads and their siblings living in CHHs. The paper shows that while children in CHHs are vulnerable, they exhibited considerable competence and capabilities to sustain themselves. However, State and NGO definition of childhood on the other hand, and cultural and local understanding of childhood produce new conceptual struggles of childhood identities that impacts negatively on children in CHHs' integration into society and their capacity to function fully. The ambivalent position of CHHs needs to be addressed if CHHs are to be recognised as an alternative orphan care arrangement.

Introduction

Although the majority of the people living with HIV/AIDS are adults, the pandemic's devastating effects reach the most vulnerable members of the society, children. Current estimates show that 1.1 million children have lost a father or mother or both parents due to HIV/AIDS in Zimbabwe (UNICEF and UNAIDS, 2006). Although one million children have lost one or both parents due to HIV/AIDS in Zimbabwe, traditional obligations of foster care to the orphans remain strong evidenced by the fact that approximately 20% of adult headed households already contain orphans (PRF/IDS/UNDP, 2003). In spite of this, the development of child headed households (CHHs) some as young as 10 or 12 years remain a major concern (Foster et al., 1997). While CHHs may represent a small minority of households in Zimbabwe (Foster et al., 1997 estimated 3 % in Manicaland province in the mid 1990s), numbers are growing in step with the pandemic. Yet very few (Foster et al., 1997 and Germann, 2005 being notable exceptions) have so far conducted detailed studies specifically on CHHs in Zimbabwe (Foster et al., 1997; Germann, 2005). Evidence from Zimbabwe indicate that while most orphans in CHHs did have extended family members who offered them help some children preferred to live alone for fear of losing household property after inheritance and also that some relatives preferred not to take children in but rather preferred to offer support to the orphans who continued to live at their parents' home (UNICEF, 2001; see also Foster, et al., 1997; Germann, 2005). However, this scant evidence is not able to indicate whether CHHs are operating entirely outside the structures of the extended family or whether they are part of some new coping system or a new form of social transformation as a result of HIV/AIDS (Chirwa, 2002) and whether these households are permanent or temporary formations. Most importantly it remains unknown how the children in CHHs are perceived by society, and factors that hinder or promote their integration.

The consequences for orphans in 'child only' units as they move from childhood to adulthood remain unknown. These orphans are often seen as children whose dreams and hopes are shattered by the loss of their parents. While the orphans' lives are a struggle and hardly 'prepare' them for life and adulthood in different ways (Barnett and Whiteside, 2002; Stephen Lewis, 2006) there is a danger of assuming that orphaned children are not survivors. If we recognise children's agency, then we need to ask how the orphans especially in CHHs are

preparing themselves to adulthood with limited parental guidance, their level of competency and resilience (Kesby, Gwanzura-Ottemoller and Chizororo et al., 2006). This is particularly important given that children heading households and taking care of siblings is a very "un-childlike" behaviour (after Aitken, 2001 and Robson, 2004) even though childhood in Zimbabwe is characterised by work and responsibilities (Bourdillon, 1997). The global and western notion of childhood is considered "a happy, free time, lacking responsibilities, a time of innocence, incompetence and vulnerably dependent on parents. The development of CHHs seems to defy the essentialist views that children are passive, incompetent and have no control over their lives. At the same time there is also a tension at the heart of academic debates too and at the heart of any policy recommendations as how to balance conceptually and practically competence and vulnerability. For example how does one explain and argue for vulnerability without mobilising stereotypical notions of the 'incompetent child'. Similarly how does one emphasise the competence of these children (that is orphaned children in CHHs) without suggesting that they should simply be left to get on with their lives (Kesby, Gwanzura-Ottemoler and Chizororo, 2006). This paper explores the attitudes of community towards children in CHHs and how these impact on the orphans' day to day life experiences and their integration into society through an examination of how local constructions of childhood are being (re) conceptualised as a result of Zimbabwe's escalating HIV/AIDS crisis.

Study area and research partners

The research was conducted in the rural areas of Mhondoro North District in Mashonaland West Province, about 65 kilometres north east of Harare (the capital city). Mhondoro North Communal Land falls under Mubayira Growth, under Norton district and Chegutu provincial town. Each district is divided into political and administrative boundaries, called WARDCOs or WARDS, which on average comprise 500 households. These are subdivided into VIDCO/EA (the smallest unit of enumeration) with on average 100 households. I selected the Mhondoro North District and Ward 8 for several reasons. Firstly the district has a small NGO that provides HIV/AIDS prevention projects and orphan care in both rural and urban areas. The NGO was set up in response to the growing prevalence of STI/HIV cases at Norton District Hospital from the communal land and small-scale commercial farms in Mhondoro North and Musengezi Districts

(now the main operating districts of the NGO. A rural community was selected because rural areas have high poverty levels and this has implications on the survival of the CHHs. Other factors influencing the choice of rural areas were related to the mobility. Urban populations are highly mobile as they move in search cheap of accommodation. This had the potential to increase the drop-out rates for the study. This decision to exclude urban areas proved crucial with the introduction of 'Operation Murambatsvina' (Operation Clean Up) implemented during the study period (May to July 2005). The operation led to displacement of urban populations who lost their homes during the operation.

Working through the NGO facilitated identification of the study area, accessing the target population, getting permission as well as field logistics. Given the prevailing political situation at the time of the study, and to avoid suspicions and safety of the study participants it was crucial to be attached to an NGO. Thus the NGO's support throughout the project was critical to the success of the field data collection. The study coincided with the time the Government of Zimbabwe was passing the NGO Bill. Several NGOs had been denied licenses to operate forcing them either to scale down their operations or close down as they were accused of supporting and funding the opposition party during their programme operations. Therefore, if the fieldwork was to be successful it was thus crucial to be attached to a local NGO, which was considered to be 'politically correct' by the ruling party. I sought permission from the both the political and traditional structures (ZANU PF leaders, the chief, councillor, the village head, head teachers, health and other key community members). Although I had planned to conduct meetings with the villagers to select and identify the study areas (and the children informants), the NGO were against the idea as this would lead to the research being 'politicised' (see also Germann 2005). Like many rural communities, unemployment is high in Mhondoro particularly among the youths and most men with paid jobs work in Harare or nearby towns. Some commute daily others only come home at weekends at public holidays. Although the rural community depends on subsistence farming for their livelihood, wage remittances also play a vital role to the rural. Women and youths with no other employment work on the adjacent former large-scale commercial farms (LSCFs)[1] where they supply labour to the new settlers and/or farmers and are

[1] Most of the farms were occupied by the new settlers

paid cash or in kind. Historically the economies of the local communal areas have always depended on incomes, however meagre, from the neighbouring commercial farms and estates (Bourdillon, 2000; Francis-Chizororo and Malunga, 2002). For most families including the children in CHHs, this paid employment, usually on a casual and contract basis provides an option that enables them to contribute to the household livelihood and sometimes pay their school fees. Despite the harsh conditions on some of the farms, farm work provides one of the few options for the children household heads who would otherwise not be able to provide food for their siblings.

Sample selection

It was my intention to recruit participants from CHH that not only contained 'double' orphans, but which also contained no adults. The NGO through its local Home Based Carers (HBCs) offered to help identify the research participants. HBCs work directly with the families in the village and were aware of the location of some of the CHHs. We also involved the local schools to identify the target population. Participants were recruited based on purposive sample and thus cannot be expected to representative. The NGO had no records of child alone households in the community despite the fact that they are running an orphan care programme. No child from the CHHs currently benefits from the orphan care programme. As I struggled to recruit the target group of research participants I realised that the orphans that are being assisted by the NGO all have an elderly person in the households who can represent them and help to access the services such as the NGO within the community. The issue of adult representation became one of the crucial issues for the children's struggle to survive. One of the committee members of the orphan care programme acknowledged that the study revealed anomalies and these basic issues around sampling turned out to be major findings of the study that will be discussed in detail in the results section. While I acknowledged that some orphans with guardians could be worse off than my actual target population (after Meintjes and Sonja, 2006), I had to stick to my conceptual definition of a CHH partly driven by my epistemological questions and to raise awareness on the plight of children living in 'child only' units, an area under researched. About five child heads

and their siblings[2] were interviewed. Five child heads dropped out of the study due to work commitments.

Data collection process

The research was conducted between May and July 2005. This was an exploratory research involving the use of mix methods of ethnographic techniques that include participant observation, in-depth interviews, informal conversations, drama, essay writing, focus groups, key informant interviews and participatory diagramming activities as ethnographic techniques applied in this research (see also Kesby, 2000; Young and Barret, 2001a b; Ansell and Young, 2003, Robson 2000 2004). Although these ethnographic approaches provides rich data, each technique has particular advantages and disadvantages in terms of being distressful for both the study informants and the researcher, and in addressing certain research questions and themes (see also Punch, 2001). The research was conducted in six phases but it was inevitable to avoid overlaps throughout the research process. The first stage involved administering a questionnaire to the child heads. The questionnaire approach was not the main method used in this study. However, methodologically the questionnaire was used to gather data about the socio-demographic characteristics of the household. Ethically it was easier to start with the more formal questionnaire approach. The questionnaire allowed certain issues to be followed up during the qualitative approaches. The second phase of the study was participant observation (PO). PO provided a more depth understanding of the informants as well the context in which they live. Further, PO facilitated the establishment of rapport with the children, which proved useful for their active participation all stages of the research. PO was a continuous method until the research ended. It also involved living with two of households[3]. The third stage entailed in-depth interviews with the child heads. The approach covered a range of topics some of which arose from participant observation. The detailed narrative interview with child head provided accounts about how the children got to where they are and the strategies employed by the household to eke out a living, the support received from family members, community, etc. This

[2] This excludes the siblings who lived elsewhere with relatives.

[3] The researchers slept over at households where accommodation was available.

included the discussion of their "experiences" of being a head and being a decision maker and the attitudes of the communities towards them. The fourth stage involved use of participatory diagramming techniques and this overlapped with focus groups and essay writing, stage five. It was not easy to group the children together for both the participatory diagramming techniques and the focus groups. Thus stage four and five were conducted on the same day. Participatory diagramming techniques provide data on the sources and social support networks for the children's survival. The accounts and experiences reported by household members through use of participatory techniques also revealed the distribution of roles and responsibilities of household members and how these are negotiated since the deaths of parents. The last stage was the key informant interviews. Interviews with professionals and community members provided data on the types of support they provide to the child headed households and their perceptions about the children in child only units. Although the mix method was important to maximise the understanding of the research questions, I remain concerned about the contradictory findings each methods produced (Valentine, 2001) as discussed in the following sections. The focus group and in depth interviews data was recorded, translated from Shona to English, then transcribed and analysed using Nudist.

Findings

The study took a substitute[4] longitudinal approach exploring children's lives before parents became ill, during the period of parental illness and after the deaths of parents in order to trace the experiences, and places through which children pass on the way toward creating their own households. Such a geo-chronological approach encourages a continual analysis of key questions: (1) how does each event and stage impacts on the children and how does it contribute to the establishment of child only units and the child's identity (2) what are the key critical points and crisis moments that require policy and programme intervention at each stage (3) from a theoretical perspective, how are local constructions of childhood being (re) conceptualised as a result of Zimbabwe's escalating HIV/AIDS crisis. Adopting the HIV/AIDS impact timeline approach used by Drimie and Mullins (2006) this study also notes children are affected

[4] It was not in fact longitudinal as I asked the children about their past, rather than having done an earlier survey.

differently at each stage and this call for different types of support as each event occurs. In addition, I am also sensitive to the difference place and space affects the orphaned children. The substitute longitudinal approach has the advantage of not responding only to the totality of the impact of parental deaths on the children but allows for the analysis of each stage and for the development of specific policy responses to each stage (pre-illness, illness and post parental deaths). For example, separate strategies to support children caring for ill-parents, and others that facilitate access to resources when parents die. This approach recognises that each stage is a process not an event or as static phenomenon, but always evolving and inter-connected and that it is a pathway into and through CHH and childhoods being (re) created.

Demographic Characteristics of the orphans living in CHHs

As noted above, only five households were sampled. The informants' (the child heads and their siblings) ages ranged between 10 and 19 years (see Table 1). The eldest child head was Mufumi[5] aged, 19 years and Tererai was the youngest aged 16 years at the time of the study. Overall, the sample contained more boys than girls. Only one girl headed a household. As shown in Table 1, two of the households (Chenjerai and Tererai) were 'lone' households. However, Chenjerai's brother had returned home from Harare after he was displaced by the Operation Murambatsvina in Harare. Three of the households were composed of siblings. They were either all boys (Mufumi), or a gender mixture, but either female headed (Chemai household) or male headed (Tendai household). Although all the child heads were not attending school, their siblings were still in school (Table 1). Tendai and Mufumi had completed Ordinary level but failed to attain the minimum required five passes that include English and Maths. Chemai dropped out of school in Form Three to take care of his terminally ill father, after her mother died first. Other drop outs were Chenjerai whose father failed to pay his fees and Tererai due to lack of birth certificate. Even though some of the children lost both parents over 5 years (e.g. Tendai household), they had only lived as CHHs for a year at the time of the study (see Table 1). This suggests migration of the orphans between adult headed households prior to becoming CHHs. None of the child heads was formally employed.

[5] Not the real names of the children

Table 1: Demographic Characteristics of the orphans living in CHHs

Household Name	Person No.	Sex	Age	Level of Educ[1]	Year mum died[2]	Year father died	Period of Orphanhood	Period of CHH (yrs)
Chemmai	Chemai	F	18	9	2003	2004	1	1
	Chigere	M	13	7				1
	Svodza	F	10	4				1
Tendai*	Tendai	M	18	11	2000	1997	5	1
	Netai	F	16	9				1
	Ndakaitei	F	14	4				3 weeks
Chenjerai*	Chenejerai	M	17	8	1998?	2001	4	3
	Mbadzu	M	23	11				2 weeks
Mufumi	Mufumi	M	19	11	2004	2001	1	1
	Rovai	M	12	5				1
Tererai*	Tererai	M	16	10	1996	2003	1.5	1

Note: [1] Level of education in completed years. Zimbabwe has a 7-year cycle of primary education, followed by secondary education Form One to Form Four (that is level 8-11), then two years Advanced level (A-Level) and tertiary education.

[2] The deaths refer to the biological mothers. Note that some of the parents divorced and remarried. Where bracket the deaths are either step parents or care givers.

? Not sure

*Parents were divorced and/or separated at the time of death. However, the deaths refer that of biological parents

Nature and pattern of parental illness

The nature of illness varied and most parents suffered from a combination of chronic illnesses, which is consistent with AIDS. Tuberculosis, which for common people in Zimbabwe has often been taken as a short hand for AIDS, was reported in three households, Chenjerai, Mufumi and Chemai. Other chronic illnesses stated included chronic diarrhoea, headache, swollen legs, malaria, herpes and sores that "never healed". The fact that I have no medical qualifications and had no access to the parents' death certificate makes it difficult to relate the parent's illness and death to HIV/AIDS. However, in the context of 25% HIV rates, it is reasonable to believe that the parents died of HIV/AIDS related illness. Children spoke about their parents' long illness as a progression from light, to moderate and then severe illness eventually ending in death. The description fits the epidemiology and the 'long wave' nature of HIV/AIDS as noted in several studies (Gadd, 2006; Gillespie, 2006; Barnett and Whiteside, 1999). The associated the illnesses with emaciation and also described "on and off" periods in which parents vacillated between sickness and relative health. "On and off" is commonly associated by most community members in Zimbabwe to describe AIDS illness, and means that good health sometimes accompanies episodes of moderate to severe illness. The fact that the child heads were using it shows that they were subconsciously admitting that it was AIDS.

Many respondents had no idea when illness started especially where parents were absent from home for long periods.

> *Mbadzu: Ah a, a [with a low voice]. We just heard [from our grandparents] that he [father] started with a cough and was later diagnosed of TB. He was in Harare then. I do not know exactly when he started to be ill because of his long absence. The problem with coughing is its difficult to say when he was ill. Usually you think it's a cough associated with a cold and would disappear.*
> *Monica: Did he cough when he came here to visit?*
> *Mbadzu: Oh yes [emphasis]. He always coughed. He was sick but "vairwara vachifamba" (He used to get around to do work at home). It was 'on and off'*
> *Q: From what you can remember how long was he seriously ill?*
> *Mbadzu: I would say he was serious for 6 months, 'on and off' .The wounds worsened but [he] managed to do some work at the house. I feel he was aware that he was too ill but he forced himself. He kind of improved. After retiring from work he ventured into a self-paying job in the village, sewing clothes a job he has been doing in Harare for many years. He got his pension and bought a sewing machine. He did a lot of sewing here but ah oh the business was not very successful. Anyway he then had these wounds that never*

healed.

Non-Disclosure of parental illness to children

In talking about parental illness, the issue of parent's silence about the nature and cause of their illness emerged as a theme of central concern of most of the child heads.

> *Mufumi: "It's a problem [to say what the parents were sick of] when dealing with adults. They just say oh my headache, oh my headache [without elaborating].*

Almost all the children stated that they were unaware of the name of the illness until a few months before they died. Where parents fail to disclose the nature of the illness, children often relied on information provided by relatives or parents' friends. However, children reported that not all parents were willing to inform them about the nature of illness. For example, Tendai's mother never talked with her about her illness and what would happen to Tendai and her siblings after her death and preferred to discuss these matters with her sisters and own mother. Similarly, Tererai's father's preferred to talk to his nephew about his illness:

> *Tererai: [recounting what his father had told him] "My son, I am very sick. I want you take care of the [other] children…However I cannot say much to you because you are still very young" He sent Bvumai [Tererai's young brother] to call his nephew [sister's son or the muzukuru]. He lives on the plots (Small Scale Commercial Farms). He is the one he talked to at length. My cousin (whom Tererai also refers to as muzukuru in the complex Shona relations) had not said anything to me about what my father said. He only says to me that father said something to him. He would tell me when the right time comes. I am just waiting and of course am curious also*

Traditionally, a nephew's powerful position as an intermediary between the cognate families means that he is trusted with keeping secrets (Gelfand, 1973). However hiding the nature of their illness from children, can result in feelings of guilt among children following the parents' death:

Even though children were not informed about the nature of the parents' illness, in most cases they seemed to competent to have determined the severity of the illness, particularly when illnesses became "visible" and/or had reached an advanced stage. Most often children observed changes in physical appearance such as emaciation, inability to walk or and being bedridden for

most part of the day. Strange behaviour due to mental illness was also reported in the case of Chemai's mother. The children also mentioned clinical observations such as fever and sores that "never healed", persistent coughing as well as episodes of being 'on and off'. Early retirement was seen as the final evidence, and thereafter children said that they "waited" for their parents to die. Tererai illustrated his ability to 'diagnose' the severity of his father's illness:

> *Tererai: The measles would bleed a lot especially after taking a bath. I think it's because he scratched them. This occurred for several days. Later the measles had pus. At the same time I also noticed that aa a a a [shaking his head] he was losing a lot of weight. He used to be a huge person. Even the way he walked uh uh ah ah (..). I was in form three*

Mufumi had a similar experience

> *Monica: You talked about him dying. How did you know that he was going to die?*
> *Mufumi: I am not sure really [that the father was dying]. (...) A.a.a ah. Okay I never thought he would die at first when he complained of headache. I thought it was just a minor illness that would go away. I only realised one and a half months later that he was very ill and was actually getting worse. He had sore legs and they were swollen. He had high temperatures [fever]. It was so frightening. I used to take him to the clinic in a wheelbarrow…"*

Chemai related a similar experience when she had cared for her mother for three days in a government hospital in Harare. Although earlier in the interview she had noted her own failure to observe that her mother was ill, seeing the mother lying in a hospital bed had clearly brought her feelings of fear and hopelessness. Her fears were exacerbated by limited emotional support from her relatives and her mother's friends who had accompanied Chemai's parents to Harare. She spoke with anger about the failure of these adults and indeed the hospital nurses to do anything that would have prepared her for the death of her mother. Chemai (then 15 years old) described tearfully[6] her experiences when her mother was dying in hospital in Harare

> *Chemai: "On Monday uuu.u.u [the night she died] I refused to stay to feed her like the other days. Mai Jenny [her mum's friend] said I should stay but I said no. You! I have never seen that. She had started shaking a sign that she was dying. I heard that if someone is ill like that and they start shaking they are about to die….. Then came the last visiting hour of the day, 5-6pm. She had deteriorated. Everyone [the visitors] just looked at her and kept quiet. It was total silence. This time nobody touched her like what they*

[6] Most of the children cried during the interviews, raising a lot of ethical issues (see also Robson, 2001)

were doing previously. Then some white stuff came out of the mouth. I took a towel to wipe her…. I said to the women that I overheard the nurses say she is dying but they [mums friends?] said it was not true. They [mum's friends] tried to move her but oh she was too heavy and cold as well. The nurses came to us and said that we should come tomorrow. She was on oxygen. I was about to cry. People held me. You know when we came back to see her at lunch we had no hope….On Monday the nurses said to me I should not feed her. She did not say why. Vanga vava kutyisa kutarisa. (She looked fearsome). She had changed so much. It's difficult to recognise a person when they are about to die. I asked myself "Is this the same person?". For example, I failed to sleep on the last day we visited her [saw her alive] that is Monday evening. I tossed and turned but sleep could not come. I think I slept around 3 a.m. I was reflecting on mum's condition all the time. She had wasted and was too ill. I questioned myself if she will ever recover, walk and come back home…"

After the deaths of parents

Becoming an 'adult'

Respondents suggested that even though they were treated like children in every other way, when they were informed about the death of parents they were expected to respond in very adult ways to the news and to show adult attributes when reacting to the death of parents. For example, Chemai's mum's friends expected her to be "strong" and "calm" and "not to cry": typically "adult" attributes.

Chemai: We [with the friends of her mother] went to the hospital as usual… My fear got worse when I saw those women [other women who had come to visit the mother at the hospital] outside and a young man (aged about 22 years) carrying mum's stuff. I said to the woman I was with, "something is wrong". I am sure the woman I was with knew what had happened [that the mother had died]. She said to me, "Let's sit on the bench….. That's when they broke the death news. One of the women said, "You have to be strong and act like a mature person, Chemai. Your mum died last night around 7 p.m." I thought I did not hear properly [that she had died] so I asked, "What did you say?". They repeated, "Mum is dead". The women cried (...). I cried on the top of my voice. They did not know what to do with me. They had to calm me down and said, "Chemai you have to stop crying because we need to plan. We need you to inform us how we can contact your father". I grew up in one day [although I was only 15 years].

Q: What do you mean you grow up in one day?

Chemai: You become more responsible. We went at a phone shop where we informed my uncle [my father's brother] about mum's death. I phoned the rural home [through the local primary school. We [with mum's friends] went to Highfields [where dad lived with his maternal aunt]. Dad was about to leave. He said to me, "Go home [to Mhondoro] to inform the community about mum's death. I am worried that they might have received

wrong information" [said Chemai in the voice of the father]. Chigere and Svodza were at home alone…. You grow up in one-day ladies. You become strong because there is no one else to arrange things for you. I went to Mbare [main bus station in Harare] Transport was a problem then because of the fuel crisis…. I travelled alone… You give yourself strength…"

The foregoing discussion shows the in-between ness of the children's situation. Relatives expect children to act like adults when their parents die. Yet they are not expected to be in charge or having influence in the inheritance process that impoverishes them. On the other hand the children are expected to "act" like adults, without knowing all the adult issues and can end up being taken advantage of as children by unscrupulous relatives at inheritance.

Experiences of Living with Relatives

Some of the orphans left to live with either paternal or maternal relatives after the death of their parents. The child heads I interviewed suggested that ill-treatment or potential ill-treatment by relatives was a major factor contributing to their decision to establishment their own CHH. This section examines the relationship between the children in CHH and their temporary guardians immediately after the death of their parents, the nature of the ill-treatment and the reaction of the children and some relatives to mistreatment of orphans. The discussion draws principally from the case studies of Tendai and Tererai's families both of which lived with relatives after both parents died. I begin with two excerpts from Tendai and Tererai taken from focus group discussion about their experiences of living with relatives.

Tendai: "The family comprised of my paternal uncle who worked in Harare but came to visit at weekends, the aunt and myself before my other sister [Netai] came to join us later. A-a-aa (...) it was very difficult to live with them [then]. I felt overworked like a "bandit" [meaning a jailed prisoner doing hard labour]. Yes I am aware that I am supposed to do work but sometimes I worked like a slave. Usually when you are being looked after you do not start by scrutinising the way they [relatives] treat you…

Tererai: "I can see [now] that my siblings and me are being ill-treated. It will be different from the way they [foster parents] treat their own children. You will be like a "bandit" as Tendai said. You feel you are in prison. Everything that needs to be done at home becomes your responsibility even if their kids are around and sitting idle. Even if you come back from school with their own kids, it's the orphan who starts working. Their

kids can go and play football in the village with friends.

These comments reflect several issues regarding differential treatment, the spatial variation of ill-treatment, the nature of the treatment and its effect on the children. In this illustrative sample, relatives tend to favour their own children than the foster children a situation that places orphans as unequal members of the household in spite of "being blood relatives". Both Tererai and Tendai reported that they contributed almost all the housework while the foster parents' own children "played". The two (Tendai and Tererai) describe their living conditions as equivalent to a "prisoner" or a "slave" when they refer to being "overworked". Similar situation occurred in Lesotho where children are "incorporated into households as workers" (Young and Ansell, 2003:470). Being overworked denies the orphans freedom and opportunities to "play" with other children in the village notwithstanding the physical strain and exhaustion the orphans experienced.

Although the orphans reported that they did not necessarily remain passive in the face of ill treatment, their reaction to differential treatment was often met by harsh words that have long-term psychological impact on them:

> *Tererai: "As times goes by you feel that it's not fair at all. The guardians often shout at you if you join their kids to play. They [foster parents] say bad words that make you think of your parents."*

Although the men had a bid say in whether the kids were taken and whether they were kept and whether they were educated in the new households but (a) from the child's perspective (b) and on a day to day basis, it was the women folk who seemed to be most powerful and influential on their immediate wellbeing. Married Shona women are often defined around their cooking hearth over which they amass great control, and therefore can use this as a weapon to ill-treat the orphans.

> *Tendai: "In any case she [the mother] is the one who cooks for you daily and the uncle [father's brother] has less control even if he likes you. Ah it's the women who have power in these households".*

> *Tererai: "What happened most of the time is that we [including the sister] never ate lunch. We were not left food at all after school (which finished at lunch time?). [He repeats the last statement]. Sometimes the aunt would say they had not cooked food. Their children especially the one I am close to [the aunt's step-child] would say to me*

that their mum [step mum] cooked food and everyone ate. Food was the main problem we faced in that household."

Although the aunts mistreated the orphans, the children did not want to inform the men who were their actual relative. Firstly, the orphans felt that disclosure of how the aunts were denying them food would worsen their position and further fuel ill-treatment given that the women have control over household food provision. Secondly, men are hardly present at home to notice what's going in the household. For example, Tendai's uncle worked in Harare before he retired to the village and that meant that Tendai spent weekdays with her aunt. Lastly the children feared causing conflict between the foster parents. Shortage of food resources impacts negatively on relative's ability to provide for the orphans, and this can create tension in the household. Following his retirement, Tendai's uncle joined the wife in the rural area. Tendai reported that the flow of income to the household declined and this put pressure on the available food resources within the household. As a consequence, Tendai found himself being informed and occasionally reminded that he should fend for himself as soon as he turned 18 years, an adult.

Tendai: "When I was in Form 3, aunt said to me, "I want you to leave this house when you are 18 years, because you will be grown up and able to look after yourself". She always reminded me about 18 years".

Q: Is there a reason why she said this to you?

Tendai: Ah! [Hesitates] Maybe it was food problems we were now facing in the house [he says this in a low voice]. [Then loudly] "I think it was because uncle had stopped work in Harare. The flow of income to the house [household] declined. That's when it started. I mean telling me what to do when I reach 18 years. There was not enough money to buy food. He [uncle] bought a plough with his pension. The pension and other benefits took too long to be released. This [lack of money] affected our relationships [between Tendai, the aunt and the uncle] in the household because things had changed [were experiencing food shortages]".

Although the child heads noted earlier that the women had powerful positions, the women's negative feelings towards their husband's relatives' children may result from lack of role in decisions making regarding orphan care. Sometimes men impose decisions to care for orphans without consulting their wives. For example, when Tendai left his maternal relatives, he said that he met his uncle in Harare and the two went to the rural home together. Tendai's aunt suddenly

found herself having to look after the children without being informed by the husband. By comparison, where woman requested to foster a child before parental deaths, they often provide love and support to the foster child, as is the case of Tererai's sibling, Bvumai. However, it is not clear whether Tererai's sister as well as Mufumi's sister were being treated fairly given that both were taken under a situation of crisis. This study did not conduct any interviews with the sister and their caregivers. They lived far away, and outside the study area.

Children's responses to ill-treatment

In this study some interfered where orphans were being ill-treated and even suggested that the orphans live alone. For example, once Tererai and Tendai's members of the extended family structures (uncle, aunts and grandparents) became aware of their ill-treatment, the families conducted a meeting to discuss alternative care arrangements. Tererai moved out of his uncle's house in the same compound and cooked separately whilst arrangements were being made for him to come back and claim his father's land in Mhondoro. The urgency in which Tererai's one roomed round hut was constructed (within a day) with the help of other villagers showed the desperation of his situation. Similarly, after a family meeting, Tendai moved to his father's cousin brother's house in the same village. The uncle and his family lived in Harare and they wanted someone to take of their homestead in his absence.

Children can be independent agents and decision makers in their own right. Even though some of the child heads had never lived with relatives, they were aware that relatives have the potential to mistreat foster children and that partly explained why they preferred to live alone. This suggests that these orphans have experiences of other orphans before they themselves became orphaned. These child heads noted that as 'children' they can be unruly at times and this can cause conflict between children and foster parents:

> *Chemai: "Suppose you do something wrong or you do not listen like failing to do your tasks. They say, "Stop troubling me! I am not the one who killed your parents". I hate these words."*

Some child heads such as Chenjerai refused to move into the household of a relative due to fear of resentment from other children in the new foster home. Even when Chenjerai was struggling

to survive and was very young (then 12 years), he declined his maternal aunt's offer to stay with him. His fears were worsened by the fact that the aunt was married in a polygamous relationship. Chenjerai preferred to stay at his parents' home to protect land and remaining property that was left (Foster et al., 1997 also observed this in their study). Furthermore, migrating to another household meant that there was no one to herd the family cattle, their only source of wealth. In addition Chenjerai noted that living with relatives denies them the freedom to make own decisions and choices. This desire for independence forced Chenjerai at the age of 14 years to leave his paternal great aunt after staying with her for less than a week after the death of his grandparents who looked after him when the father died:

> *Chenjerai: "If you stay with relatives you have no choice for example the choice to choose what you want to eat or the freedom to say anything. For example if they cook food you do not like, for example derere (okrah), which I hate, they say, "Where do you think you will get the food?"*

Where relatives invite children to live with them and the orphans refuse, this can be met with anger and irreconcilable relationships between orphans and the relatives concerned. When Chemai's father was ill, he advised her not to leave home because he feared his brother would take over the homestead including the land or sell both even though none of the relatives in this study disputed the children's inheritance of land. Chemai's desire to fulfil her father's dying wish outweighed the risk of losing contact and support from her uncle:

> *Chemai: "[the uncle said] that's what you want [not to leave the parents' home to live with me [uncle and his family in Harare]. So do not expect any assistance from me".*

The Shona beliefs that a misfortune can strike if one disobeys a dying person's wishes made Chemai defy her uncle's suggestion to sell the homestead and to go and live with him and his family in Harare, apart from her desire for freedom and fear for potential ill-treatment. Chemai's experience to inherit land is unusual and significant given that women rarely inherit land in practice, even though the general law now allows female inheritance of land. Chemai's decision, though revocable, has been hard to live with, not only due to her desire for uncle's support, but because of the struggle she experience to fend for herself and the siblings.

Attitudes towards child headed households

Community perceptions

Given the logistics and the methodology it was not possible to ascertain the views of the children's own families about their becoming CHHs. However, it was possible to explore what the community in general felt about the children in CHHs. Part one of this section reviews the predominant attitudes of the community towards orphans. The findings are based on informal interviews with villagers and key informants. As noted earlier, the development of CHHs is a new phenomenon in Zimbabwe. At present other community member's perception of CHHs seems to be mixed, with both negative and positive attitudes being expressed (see also Germann, 2005). On the negative side, the poor living conditions of the orphans were a major concern from the villagers. Indeed some villagers were prompted to provide us with food during data collection process because they knew children could not feed us. When adult interviewees were asked to characterise orphans (note: not specifically CHH) people tended to identify them in the following ways: dirty children; school dropouts; always borrowing; working to survive, and having no food.

Villagers who showed greater concern for the plight of the orphans displayed a sense of obligation to provide support to the orphans. "Well-behaved" orphans tended to receive sympathy and support from the community. Statements such as "He is a child who respects and listens to elders" were common to Tererai from his aunt and the village head and other villagers. Similarly villagers liked Chenjerai for not abandoning the rural home in search of fulltime employment at the nearby farms or towns, unlike his elder brother and cousins. Not only do communities sympathise with children with good behaviours and came from a good family, but also sympathise with those that were neglected by relatives after their parents died or experienced ill-treatment from temporary foster parents.

> *Key informant (female):"Look at Chemai for example [with a sorrowful face] she has an uncle his father's blood brother and he is well off. He drives a car and has a working wife. But he has never set foot since the death of Chemai's parents [Chemai had also said the uncle had only visited them once since the father died]. Yet he comes every month and drives past Chemai's house less than 500 m away]. He just passes without even stopping to see the children. He will be visiting his in laws. The wife comes from here. May be they [parents] were not seeing eye to eye with the brother [village head confirmed this]. But he [uncle] took him [father] to Harare when he was sick and buried him there [without telling the children of his death even though the man's daughter [Chemai] had cared for him for a whole year]. Chemai has got relatives. She [Chemai] has a half brother [older*

than her but age unknown though he is unmarried] but [he] is nowhere to be seen. She has maternal relatives who are in Mutare… It's so painful for her to support the [other] children [without support] when she has all these relatives…."

On the contrary, where orphans were viewed as "unruly", communities not only provided little support but they also isolated the orphans. For example Mufumi was suspected of growing and selling marijuana. Although growing marijuana attracts a minimum jail sentence of 7 years in Zimbabwe, smoking the weed is a common local practice but is disapproved of generally and especially among children. Furthermore, Mufumi was suspected of stealing, and although this could have been a strategy to survive, such behaviour lead to his being ostracised by the community at large, including the village head.

Village head: "I do not want you (referring to us-the research team) to assist Mufumi. He is a problem in the village…He is a thief! Everyone complains about him and we want them [and his elder brother currently in jail] out of the village. I have contacted his uncles (one of them is the councilor) about this decision…."

Although some key informants associated orphans with "wild behaviour", they also blamed relatives for neglecting orphaned children and "not following tradition" (i.e. not taking in the orphan.

Orphans' Perceptions

While many un-related adults' views were concerned about the orphans' behaviour, child heads themselves were worried with issues of achieving social integration into the communities in which they lived. One of the child heads stated that they suffer a "triple tragedy": (1) the loss of parents [may be due to HIV/AIDS related illness], (2) ill-treatment from relatives, and (3) the difficulties of acceptance and community integration which affects their ability to meet daily needs. The third point is the main focus of this section. Child household heads' voices remain un-heard within the family and at the village level. Although some child heads (Tendai, Mufumi and Tendai) stated that they had been allowed to participate in their parents' funeral and after death, they mainly acted as observers because of their young age. Furthermore, the majority of the communities did not accord these CHHs adult status even though some of them had reached

the legal age of majority (LAMA) (18 years old) at the time of the study. Even though some of these older individuals reported that they were called to attend village meetings (an invitation normally only extended to 'full/married adults'), they felt marginalised at these events because they were usually assigned 'child like duties' such as running errands for the community leaders:

> *Mufumi "…They [community leaders and villagers] see us as children's households. We sometimes are invited when there is a community meeting. And when we are invited, they [local leaders just] say go and call so and so [adults] as if you do not exist in the village. This is when you realise that they are treating you as a child who knows nothing".*

Concurring, Tererai (aged 16 years) suggested

> *Tererai:"…That children [us as child heads] are excluded is the norm in our everyday lives…"*

Yet the community assigned the child heads adult roles when it suited them. For example, the child headed stated that they are expected to participate in community related work activities such as funerals, repairing boreholes, soil conservation and many others. Another example of children community work is that in the event of a funeral in the villages, the young male child heads are expected to assist with digging the grave, while Chemai helped with the cooking and comfortig the bereaved family. The child heads interviewed said they were forced to participate in community work as a social and reciprocal obligation because the villagers were their main source of support.

> *Q: Why do you have to do these community activities? Is it compulsory?*
>
> *Chemai: " Iii . Iiii Ah You! [With a face to say I should know this]. I have to be seen participating in these community activities, in case my sibling also dies or get sick. What will happen if no one comes to help me also when my sibling gets sick or dies? Remember I told you about the tractor incidence in which I was hurt and was sick for many weeks. Villagers came to assist me with bathing, cooking, nursing me. Some of the women even slept over to check on me. It's all because I do help a lot" [discussion conducted during observation and participation]*

During the study, Chemai sent her his brother to represent her household at a memorial vigil for a neighbour. Even though the child heads expect to participate in community labour activities as an extension of their household work, they not only felt overworked as a result, but also feel

exploited, as the community seemed to involve them when their labour was required.

> *Tendai: "These people (the villagers) recognise us when there is demand for community labour. They say go and work [repair boreholes] because you have young blood [energetic]. But regarding access to food aid we are not counted. They [adults] say that we are children as if we do not eat [their households are often excluded as they are regarded as child households]*
>
> *Chenjerai): Things are not fair in the villages because when it comes to receiving food aid they say we are able bodied and are able to source [our] own food. They say 'matova madhara' meaning old people [and are old enough to source food by working on the farms] [He makes a sound used to show anger].*
>
> *Chemai People see us as parents because of the household roles we do as the eldest…As a result of these roles we play, society [villagers] even expects us to participate in community work and functions such as funerals"*

The child heads reported that having no parent or an adult in the household is often a disadvantage for young CHHs. All the child heads reported that they require an adult representative to access material needs.

> *Chenjerai: It was very difficult to access the food. I forced myself in [to] the programme after my [adult] neighbours represented me. I even went to Chegutu with a neighbour to find out why my household was not on the list. But they said the village head provides the list of beneficiaries and they could not do anything [confirmed by the neighbour during an informal conversation].*

Similarly, Chemai's household was removed from the village list of names of beneficiaries for the food aid programme after the death of his last surviving parent, her father. Although she did not know how her household was de-listed, she noted that it was due to her young age [she was aged 17 years at the time]. Chemai recounted her three-month struggle to have her name and her household's name back on the village list during a time in which other villagers continued to receive food aid from the Catholic Relief Services (CRS) at the peak of the 2003/4 drought.

> *Chemai: I support Chenjerai [during the focus group discussions] because I faced a similar problem in my village. The elderly always said that we could not receive food aid because they [adults in the village] say to us, "You are still young and are able to work. You can jump onto the tractors." I failed to get food aid [cooking oil, bulgar [a variety of wheat] and beans for three months. I approached CRS officials [local staff working for*

the international agency]. The woman said that [why my name was not on the list] it was a computer problem as it failed to read my name, as I was less than 18 years than then. No one in the village wanted do have their names removed so that mine is included and yet the majority had working spouses. I cried. My friends always laugh at me now when they see me because I cried as if someone had died. It was the kids [her siblings] I was worried about…."

Negotiating Headship in the child headed household

I was interested in finding out whether the CHHs mimicked the 'normal' Shona households headed by adults and which have clear age and generational hierarchical structures. Although I left open the possibility that there could be more than one head, in this study all children indicated that single individual as the household head. Being the eldest (except in the case of Chenjerai's household) emerged as the most important feature that defined a head in a CHH. That the eldest child was responsible for other household members is consistent with the principle of generational hierarchy observed across Shona culture and practice. Households were called after the eldest member (irrespective of gender) who usually resided at the homestead, that is Chemai's house or the house of Chenjerai. Although this is the same to the way adult headed households are referred too, the difference is that adult households are usually referred to after the male head of the household. In this study the community referred to as Chemai's household despite her gender (female). Headship seemed not to be contested but to be treated as a given based on age superiority. Cultural expectation makes older children's obligation over young siblings compulsory.

Chemai: "In fact you are obliged from a rights [cultural] perspective to play these parental roles as the eldest in the household, and the main provider even if you are still a child".

Although the child heads do not see themselves as mum or dad, they described their roles as providing food for the siblings; giving advice to the younger ones than themselves in the way adults would advice children (though often this will be the role of an aunt or an uncle rather than mother or father), making decisions, participating in community related non-paying activities, paid work and providing support for siblings living with relatives elsewhere.

Relation between boys and girls in child headed households

The study revealed that although adolescent boys (irrespective of the age) exercised control over girls in the absence of parents. Ever since Tendai lived with his two sisters he has never sent them to the shops, the reason being that vanonyengwa netukomana (the boys would ask harass and ask them out). The issue of boy's control over adolescent girls often create tension and conflict between the two sexes. Particularly intense conflict was noted where girls started having relationships with boys. However from the data collected, it was not clear whether the relationships were to raise resources, or they were just boyfriends. Chenjerai and one of his friends narrated an incident where Chenjerai beat his cousins for bringing boyfriends into the household to sleep over. A similar incident was reported as having occurred in one of the household that eventually dropped out of the study where the male child head (aged 20 years old at the time of the incident) beat her two adolescent sisters of 15 years for having boyfriends. This reaction is a very "adult" response to instances of youth sexuality. Mbadzu described his cousins (girls) as very "naughty", "uncontrollable" and "lazy" in the absence of parents or an adult in the household:

> *Mbadzu: We never experienced food shortage in this house. The grandparents were great farmers. We grew a lot of maize and used to sell surplus. So people started leaving one by one mainly due to hunger. They (the girls) were lazy. They did not want to engage in farming. So they left and went to live with boyfriends. There was nobody to control the girls. It was mazvake-mazvake, madiro (each person did what they wanted with no one to control them). The problem with girls is that they do not want to be seen working on the fields at home ((sharp contrast with Chemai who is well behaved)). These girls spend most of the time at the shops. But they used to work on the fields when our grandparents were still there. I think it's because they were forced to go and work. So they left when hunger struck the household.*

Discussion

The notions of the classic western version of childhood and also local customary understanding too are being challenged with the advent of HIV/AIDS in Zimbabwe. In this study children were often perceived and regarded as vulnerable, incompetent and in need of protection often leading to their ability to managing their own lives being overlooked (Valentine, 1997; Prout and James, 1990). In traditional Shona societies not only was the extended family more involved in the

upbringing and the socialisation of children than it is today, but the community also played a stronger role, and the child belonged to everyone. Shona childhood was very complex because children were seen as very competent, as they took take on considerable responsibility for tasks and for other siblings in a way western kids rarely do (or did). Despite that fact children are granted considerable practical competence in Shona society, they are not given credit for moral, social competence or given the right to make decisions independently.

In this study, the parents' illness was a guarded secret from the children until the parents became terminally ill and death became imminent. The aversion to talking about their illness was not without basis as children in Shona society cannot be trusted with keeping secrets about their parents' HIV/AIDS related illness especially in societies where HIV/AIDS patients are stigmatised and discriminated against. The failure to inform children about the illness of adults has deep roots in traditional Shona culture. Meursing (1997:207) noted that while an individual facing a major health problem would often consult elders in the extended family (paternal relatives) they would not discuss the matter with children because they are "regarded as ignorant" and too young to understand illness. Yet children can keep secrets when they are so serious and when they are taken seriously and taken into confidences, but adults often do not believe they are capable of this. Children need to be informed about parental illness to avoid feelings of resentment, anger and trust (Wood et al., 2006).

From the perspective of adults, the problem about talking about HIV/AIDS with children is that it undermines adults notion that the innocence of children needs to be protected and issues of sexuality including HIV/AIDS are considered taboo for adults/parents to discuss with children (see also Gwanzura-Ottemoller, 2006). In the context of HIV/AIDS this is particularly difficult, because the sexual matters they would have to discuss would not even be in the abstract but would necessarily involve revealing something about their own personal sexual behaviour. Added to this is the general stigma associated with HIV/AIDS, and it is possible to understand the rational that underlies the seemingly irrational decision not to inform children about the inevitably terminal nature of their ongoing illnesses. An additional factor may be that parents want to protect children from the upsetting truth. As a consequence, parents kept their children ignorant or provided them with superficial information about their illness. Yet the children had

some kind of contextual sense of the imminent death in the view that they lived in communities where such illness and deaths are frequent and were aware of other children's parents dying around them. Further, they "knew the bad signs" when their parents (fathers) retired in their early 50s or were sick "on and off" an expression commonly used to refer to HIV/AIDS related illness in Zimbabwe including the study area.

Although the emotional and psychological effects of withholding information from children are far from clear (Germann, 2005) the orphaned children in this study reported their anxiety in witnessing parents debilitating illness. In this study there is no sense of whether any younger siblings in the household witnessed their deteriorating and dying and the issue of silence and secrecy surrounding parental illness. In addition the study did not capture if the child heads talk to their siblings or friends about their experiences or if my interviews with them were the first time they had discussed these deaths. Perhaps the behaviour pattern set by the parents and other adults means that children feel that they cannot or should not discuss these issues. As they narrated the detailed accounts of their parents' severe illness and subsequent deaths to me, most participants talked about how they had worried about parents' illness, the persistent cough and the wounds that never healed. Even though they coped during this period, taking on adult caring roles, they still worried about who would provide care for them when the parents died in a society that does not accept the independence of unmarried youths and children.

Paradoxically, while the parents did not want to discuss their illness with their children, they expected their children to shoulder the burden of caring for them while they were sick (Chemai's story) and some requested their eldest child to look after the younger children when they died (Tererai and Chemai). This indicates tension and inconsistence in how parents view children. It is indisputable that parents are failing to conceptualise their children's full competence and potential: they contradict themselves by treating children as 'children' (by not disclosing their illness) and then as 'adults' (when they expect the children to head the household and take care of siblings). This confusion among parents raises the question: When does childhood begins and ends in the context of HIV/AIDS among the Shona people. While childhood in Shona culture traditionally ended with marriage (see Schmidt, 1992), in the contemporary period, pre-mature HIV/AIDS-related morbidity and mortality are the socio-biological phenomena determining the

beginning of Shona adulthood. The changing nature of childhood in Zimbabwe confirms Valentine's (1997b) idea that childhoods are cultural inventions and ideologies that are (re) constructed and (re) produced over time. While Shona childhood has always been filled and structured by a mass of household responsibilities, the HIV/AIDS pandemic has created a new form of childhood where children [child heads of CHHs] are expected to take full adult responsibilities and behave as adults do such that the community even refers to the children as 'mother' and/or 'father'. These statements suggests (a) the signs of a begrudging recognition of the mature and adult status of children (b) or (and/or) an attempt in some way to maintain traditional notions, that is labelling the kids with heterosexual marital social norms, rather than recognise their independent unmarried social status. Moreover it confirms the theory that childhood is a social construct and social relation, that is if one is doing what adults do then society is in some then compelled to label that individual an adult.

Expressions such as "if you are a mother now then act like one" is an attempt to reinforce existing social norms of virtual motherhood and fatherhood even though the traditional mechanism of marriage no longer plays a direct role. This is particularly evident when Chemai's mother's friends told her to behave and 'act like' an adult by not 'crying' when they informed her that her mother had died. In the context of HIV/AIDS illness and death of parents determines adulthood. Identity is therefore relational; it is not something one can simply make for one's self. These accounts (e.g. Chemai's experience) seem to confirm that while children are highly competent, how they get positioned is often out of their hands. Adults sometimes treat them as children, sometimes as adults and what children can and are expected to do changes accordingly. These positions and identities are dynamic and unstable across time and space. Chemai described her experiences after the death of her mother as a turning point to her life, which she changed from being a "young" girl to a mature and responsible person, "I grew up in one day". From the very day of the death of one or both parents the (eldest only) child enters a strange, complex and ambiguous positionality, somewhere between child and adult, but neither fully one of nor the other. Therefore CHHs occupy this difficult in between status whose households I shall refer to as 'sandwiched' households. Even then this in 'betweeness' is not stable, it is not always in the same position between, but moves sometimes towards a more adults status and sometimes towards a more child-like status. Kids try to take control of this but the socially

available resources they have available mean that they cannot simply take control over their positionality.

Although the ambivalent position of CHs is detrimental to their survival, as they can be exploited and excluded from development projects targeted at vulnerable children, at the same time the complex nature of their positioning is crucial for their survival. This position of the child heads is highly inter-subjective and depends on intimate familial and intimate social relations that influence their integration into society. The child heads need to be on good terms with the community. As a result, the child heads have to accept this positioning because it's crucial to get community support; and yet at the same time such positioning is detrimental to their struggle for survival for reasons stated above. Therefore, the situation of orphans in 'child only units' is very complex indeed. Refusing to engage in collective community activities would imply lack of community support among children from CHH. Moreover, social networking with adult headed households in the community allows them access to information and resources important for their survival. This demonstrates that orphaned child heads must not only take on 'adult-like' parental roles, caring for their siblings within their own households, but must also take on 'adult-like' responsibility at the community level to ensure that they and the siblings establish good relations with villagers who are their main sources of support.

Sadly, for many heads of households interviewed in this study, heading a household does not mean that the community would treat them as adults even if they are above the official age of adulthood of 18 years. Many child heads and their siblings continue to be marginalised and unrecognised as was shown when the NGO we worked with during the fieldwork had difficulties in identifying the CHHs for us to interview (see also Kesby, et al., 2006) but could easily identify orphans in grandmother headed households. At the same time, adults conveniently appealed to and mobilised modern legal definitions when it suits them (Tendai's experience) even though turning 18 would make very little difference to the children's ability to look after In Zimbabwe (at least before the most immediate economic collapse) many young people aged 18 are still at school and therefore unable to fend for themselves economically, especially given the lack of availability of state social security as in the developed world. In addition, socially, 18 year olds will not be treated as adults and so cannot apply for food aid or land in their own right.

In this illustrative study, the extended family structure was a space where the orphans taken in by relatives had limited time to play and socialise leading to them 'running away' as Sibley 1995b (quoted in Beazley, 2000) summarises regarding the home.

> The home [household] is one place where children are subject to controls by parents [caregivers] over the use of space and time and where the child attempts to carve the use of space and set its own times. The possibilities of conflict here are considerable. Children may find the domestic [including relatives' foster homes] regime oppressive because of rigid parental control of space,……(129)

Ill-treatment makes orphans desire to find ways in which they create own social worlds over which they feel they have more control. This is not simply saying kids are "restricted" by foster parents, because they are "restricted" by their own parents. In a way these points make it more likely that children's stories of mistreatment are true because "normal" family life has many burdens and restrictions for children. But choosing a CHH is a pretty extreme and risky choice to make especially when some of the children lived with no parents at the age of 14 (see Chenjerai). Some of the children reportedly chose to opt out of the 'hostile' domestic environment to avoid more conflict with the foster parents. The point here is that the orphans are already traumatised from the effect of parents' illness and deaths, and ill treatment by relatives and their only wish is to seek for freedom and independence from an abusive environment. This again shows the importance of interfamilial relations in influencing the development of CHHs. Therefore orphans are providing a new model for doing childhood. Orphans are different to other children not only because they are treated more harshly than parents would treat their own kids, but because in some desperate sense they have a choice. They can walk away from the household in a way that most other kids do not. This suggests that the orphans are providing a new independent model for childhood as a result of ill treatment. The orphans' departure from the relatives also reflects the historical strategy of resistance to unbearable situations and a desire to search for freedom and emancipation by young women and girls during the colonial era (see Schmidt, 1992, Barnes, 1992, Kesby 1999, 1996). The orphans' resistance supports literature from radical feminism where male [in this study caregivers] are seen as women's oppression [orphans' oppression] and moving out of the caregivers' household to create alternative satellite households in which the orphans live alone becomes the norm (see Chant, 1997).

This movement from repressive extended family structures households provides an opportunity for orphaned children to create their own household, a new space of power in which they 'hope' to define their own social identities. In this study the child heads noted that although some people laughed at them (e.g. calling them 'tiny hut' in the case of Tererai) they value their households because they define who they are: "lone orphans". At the same time the new household formations become a locus of identity formation through the establishment of social networks and survival strategies. However these particular socio-spatial formations are radically different from those that dominate the rest of Shona society because households as socio-spatial entities are usually identified or associated with married adult identity. The fact that by the time parents die, household resources are depleted often means that CHHs struggle to fully perform all the functions 'normally' associated with household. In this study the CHH became a site of conflict over roles and responsibilities between the household members. In one of the households that had contained teenagers, conflict emerged over gendered work roles. Girls tended to fulfill their culturally defined roles but boys were not. In this study, boys felt that girls were challenging their patriarchal authority and control. However, although boys attempted to exercise control over girls' behaviour, girls resisted by; (1) refusing to cook when they got home from the local shops if they had already eaten food bought by their boyfriends and (2) running away to live with their boyfriends or in search of work on the nearby farms where no one controlled their behaviour. Such strategies have a long history as forms of resistance as first, wives who were displeased with husbands (e.g. husbands who do not bring resources) refused to cook or to cook good food such as chicken. Second girls have long escaped the communal lands and the surveillance of fathers/brothers and the community for a "freer" life on the farms. The response of girls to run away represents some kind of normal situation. Girls are expected to move away from the parental home at some stage of their lives in particular when they go to get married. As a result it is not their duty to secure the "paternal" household. However, the key point is that normally their departure would be accompanied by an inflow of resources, roora. It would seem that the boys regret this lack of exchange of resources and the lack of bridewealth could be another reason why CHHs might remain impoverished.

Conclusion and Recommendations

Many children were not informed about parental illness and deaths. They had no choice in deciding whom to live with after the deaths of parents. Yet many were able to observe the extent and severity of the parent's illness before they died. As the number of orphans and CHHs continue to rise, communities need to redefine traditions and culture of exclusion to include children in issues that affect them especially where deaths is imminent. Children need to be prepared for parental death so that they are less traumatised by the experience and are may be able to cope with it. There is a major need to educate the community about the nature and experiences of CHH and to engage them in discussions with children from CHH that enables such children to participate in decision-making process.

My experience during data collection process is that CHHs will continue to grow given the growing number of AIDS related deaths among young to middle aged people and the natural deaths among grandparents currently looking after orphans (see Matshalaga, 2002). Despite the potential increase in CHHs, data is extremely limited especially in Zimbabwe (with the notable exception of Foster et al., (1997) and German (2005). There is need for further research on CHHs to better understand their experiences and inform policy and programme interventions notwithstanding the theoretical contributions. This study was limited in its geographical coverage and scope. Thus there is need for a nation-wide research on CHHs that could address the following findings of this study: (1) the gender dimensions of CHHs, (2) the psychosocial impact of parents deaths and living as CHHs, (3) coping strategies (4) understanding the dynamics of orphans living under foster care.

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