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Child Headed Households, The emerging Phenomenon in Urban informal Settlements: A case study of Kibera Slum Nairobi -Kenya.

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DECLARATION

I declare that this project is my original work and has not been presented for a degree in any other university.

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DEDICATION

To my husband and my children, Cynthia, Gloria and Ryan who have been a great inspiration and encouragement. To my late mother Monica, she taught me the virtue of hard work and the value of education.

List of Acronyms

AIDS	Acquired Immuno Deficiency Syndrome
CBO	Community Based Organization
CHH	Child Headed Household
FBO	Faith Based Organization
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
NGO	Non Governmental Organization
OVC	Orphaned and Vulnerable Children
UNCRC	United Nations Convention on the Rights of the Child
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Program
WHO	World Health Organization
WSHG	Women Self Help Group

TABLE OF CONTENTS **Page No.**

Abstract

Orphans living on their own in child-headed households (CHHs) are a new, but growing phenomenon which was first noted in the late 1980s in the Rakia district of Uganda and other parts of Africa which have been badly affected by HIV/AIDS (WHO 1990). With the traditional extended family and community support networks disintegrating, many orphans now live on their own in child headed households. Although AIDS is only one of several factors leading to the changes being observed in traditional patterns of child care (Foster et al 1995), it is undoubtedly the main factor predisposing to the establishment of child-headed. The study examined factors surrounding the emergence and persistence of child headed households in Kibera slum, Nairobi The objectives were to establish; the causes of the emergence of child headed households; the challenges they face; the source of emotional, material and financial support and the channels of survival used by children in these households.

The study was carried out in four out of seven villages in Kibera. These were Lindi, Kianda, Laini Saba and Makina. These villages have the highest population of orphans and vulnerable children and also host most orphans support projects. The basic unit of study was the children living in child headed households. Both primary and secondary data was collected to increase the reliability of research findings. The questionnaire, observation guide and key informant guide were used to collect data.

The study found that many ailments and deaths coupled with the breakdown or weakening of the extended family network has lead to the emergence of Child headed households. Children in these households are faced with many challenges such as lack of parent's love and affection, protection and care, Lack of basic necessities like food shelter and health care, social exclusion and stigmatization, disinheritance, exploitation abuse. The study therefore recommends: interventions which promote sustainable solutions to child headed households; development of programs which address needs of adolescents; skills training for children in child headed households on issues of reproductive health, children's rights, drug abuse, home management and conflict resolution.

CHAPTER ONE

BACKGROUND AND PROBLEM STATEMENT

1.1. Background

Although AIDS is only one of several factors leading to the changes being observed in traditional patterns of child care (Foster et al 1995), it is undoubtedly the main factor predisposing to the establishment of child-headed 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.

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. In some instances, poor families have been found to be more receptive to orphans while wealthier relatives, whom one might expect to be more able to foster relatives' children, maintained minimal links with orphans. 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 stigmatization.

Although the majority of the people living with HIV/AIDS are adults, the pandemic's devastating effects reach the most vulnerable members of society, children. Whereas HIV/AIDS is a global issue, it disproportionally affects Africa, which remains at the global epicentre of the HIV/AIDS pandemic. Although in Africa working and taking responsibility are not activities peculiar to orphans, what is unique to CHHs is that they must assume all the

roles once performed by their parents and other adult members of the extended families. Like elsewhere in Africa, orphans in Kenya would traditionally have been cared for within the extended family system in families headed by adults. However this is not the case. Existence of CHHs can be construed to mean that the kinship-based family system is deteriorating and is no longer coping with increasing numbers of orphans.

Child headed households have been noted in the late 1980s in the Rakai district of Uganda, child headed households (CHH) is a phenomenon that is attributed to the breakdown of the extended family structure. Other causes attributed to the emergence of the phenomenon include the HIV/AIDS scourge, children being orphaned through other causes and a parent being disabled.

1.2. Statement of the Problem

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 (Nuerland 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).

The phenomenon has been observed in other parts of Africa which have been badly affected by HIV/AIDS. This phenomenon is has resulted from the overwhelming number of orphans caused by the HIV/AIDS scourge. With the traditional extended family and community support networks disintegrating, orphans in CHHs have had to depend on their own resilience by developing a continuum of coping and survival strategies (Luzze F. 2002). Child headed households are evidence of the collapsing and failing community support networks but also one way in which extended family is adapting to cope with problems produced by HIV/AIDS. Hence CHHs is an emerging problem in Kenya and just being documented unlike in other counties. For this reason the aim of this study is to

find out the patterns of survival in child headed households and how children in these households relate with other members of the society.

The phenomenon of child headed households has been reported in academic and non-governmental organizations circles in the past few years, due in part to HIV/AIDS crisis in Sub-Sahara Africa, and has also featured in the analysis of vulnerable children in the context of situations of conflict and displacement (MacLellan 2005).

AIDS is a large and growing problem that has already taken a great toll on the lives of many people and their communities especially in Sub-Saharan Africa. The region alone has 24.5 million of the world's 34.3 million people living with HIV/AIDS and more than 11 million Africans have already died due to AIDS (UNAIDS, 2000). Unless a cure/vaccine is found, the disease, which is now the leading cause of death among adults in the region, will be responsible for 39 percent of death among adults in Sub-Saharan Africa by the year 2020 (World Bank, 1989).

Before the emergence of AIDS, about only 2 percent of children in the developing world were orphans. By 1997, the proportion of orphans with one or both parents dead had risen to 7 percent in many African countries and in some cases reached an astounding 11 percent (UNAIDS, 2000).

For countries like Kenya that have had long and severe epidemics, AIDS is generating orphans so quickly that conventional orphan care systems can no longer cope. Yet through the accompanying waves of impoverishment and social disintegration, it also destroys the very social fabric necessary for absorbing the growing number of orphans. This two-pronged effect of the HIV/AIDS scourge, it can be emphasized is directly responsible for the emergence of CHHs. In order to escape the encumbrance of being adopted by relatives in households where resources are already over stretched, or being institutionalized; many orphans leave for urban centers either to become street children or to provide cheap labour. Others, especially girls are lured into early marriages and some are exposed to sexual exploitation as child prostitutes. Increasingly however, rather than

choosing the above options, more and more orphans are choosing to stay behind in their communities to run their own households. All have suffered the tragedy of losing one or both parents and many are growing up in deprived and traumatic circumstances without the support and care of their immediate family. Without the protective environment of their homes, they face increased risk of violence, exploitation and abuse. Therefore this study is designed to find out how children in child headed households pull through and the kind of challenges, obstacles and deprivations they face. For examples, what are the experiences of being in a child headed household.

Despite living under very pathetic and harsh conditions, orphans in CHHs have been known to develop unique resilience when their lives are changed radically. They develop a continuum of coping strategies, which also include adopting 'de facto' adult roles. Hunter (2000) for example observes that, "Children take on new roles, acting as household heads, making household decisions even when parents are still living, and supporting their young brothers and sisters, at times suffering loss and peril themselves Because of the overwhelming stress on the conventional orphan support systems, increasingly, CHHs are slowly becoming an accepted alternative form of orphan care and are thus attracting support from communities, women self-help groups (WSHGs), CBOs, Churches and NGOs.

1.3. Objectives

1.3.1. General Objective

The main objective of the study is to examine factors surrounding the emergence and persistence of child headed households in Kibera slum, Nairobi.

1.3.2. Specific Objectives

1. To find out the causes of the emergence of Child Headed Households.
2. To find out the channels used by children in Child Headed Households for survival.
3. To establish the source of emotional, material and financial support for children in child headed households.

4. To find out the challenges children in child headed households face.

1.4. Research Questions

1. What are the challenges faced by children in child headed household?
2. What channels of survival do these children leaving in child headed household use?
3. What is are the societal responses to the phenomenon of CHHs?

1.5. Scope of the study

This study will focus on the factors which are contributing to the emergence of CHH in Kibera Slums, Nairobi, Kenya. It will investigate such concepts as household, child headed, child, head of household, survival patterns for children in CHH, their relationship with other members of society, the challenges and deprivations faced by children in CHH. The study will seek to understand the experiences of these children and the relationship between gender and survival in these households.

1.6. Justification

Various studies have been done on orphans and vulnerable children on institutional care. For example: Africa's orphaned generation by UNICEF 2003. Other studies on Child Headed households have also been conducted in other countries like South Africa, Uganda and Zimbabwe for example; Factors leading to the establishment of child headed households: the case of Zimbabwe, by Foster 1997. There is need to conduct a systematic study of child headed households to understand the underlying causes to the emergence of child headed households especially in the urban informal settlements in Kenya. It is also important to understand the experiences of growing up in these households beyond the obvious surfaced deprivations. This encompasses focusing on the psychological trauma of observing a parent's terminal illness, dealing with death, the absence of adult guidance and mentoring and the need for love and security.

1.7. Definition of Key Terms

Child

The UN Convention on the Rights of the Child (UNCRC, article 1) defines a child as a person up to the age of 18 years. This is in line with the Kenyan Constitution which defines a child as person below the age of 18 years. This definition of a child has been adopted through out this study.

Orphan

An orphan in this study refers to any child under the age of 18years who has lost one or both parents.

Head of household

The household head is the person primarily responsible for the day to day running of household, including childcare, breadwinning and household supervision.

Child headed households

A child-headed household is one which is led by a child under the age of 18. This child takes on responsibilities usually carried out by parents, including providing care to other children and sometimes to a sick parent.

Household

They include siblings, children with an incapacitated adult, extended family or an arbitrary grouping of vulnerable united against misfortune.

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

The purpose of doing this literature review was to gain more information on the challenges facing the AIDS orphans in Kibera slums. The study utilized secondary sources of information mainly books, journals, government policy documents and reports. The literature search for this study was done with the search of key words such as HIV/AIDS, Orphans and Vulnerable children, impact, Kibera slums, Challenges and stigma, coping mechanism, The literature consists of selected articles on AIDS Orphans, Child headed households and the challenges they get in Kenyan slums and other developing countries in general. In addition, some educational publications such as journals on HIV/AIDS, Orphans, impact of AIDS on families, related publications from the newspapers, and articles from WHO, UNAIDS, USAID, and UNICEF among others ware reviewed.

2.2. Child labour in Kenya

According to ILO, Africa has the highest incidence of child labour with about 41 percent of all its children aged 5-14 working. Asia is second with 21 percent followed by Latin America with 17 percent. In Africa, Mali has the highest percentage of working children with 54.4 percent, Bukina Faso with 51.1 percent, Burundi 49 percent, Uganda 45.3 percent and Niger 45.2 while Kenya ranks sixth with 41.3 percent.

The 87th Annual ILO Conference adopted the Worst Forms of Child Labour Convention of 1999. The new Convention applies to all persons under the age of 18. This age limit is pegged to the ILO's Minimum Age Convention of 1973 (No.138) that remains the bedrock of national and international action for the eventual total abolition of child labour, and which had been ratified by 74 states as of 1999.

The new Convention defines worst forms of child labour as: *(i)* all forms of slavery or practices similar to slavery such as sale and trafficking of children, debt bondage, serfdom and forced or compulsory labour; *(ii)* forced or compulsory recruitment of children for use in armed conflict; *(iii)* use of a child for prostitution, production of pornography or pornographic performances; *(iv)* use, procuring or offering of a child for illicit activities, in particular for the production and trafficking of drugs; and *(v)* work which is likely to harm the health, safety or morals of children An accompanying Recommendation defines: *hazardous work* as: work which exposes children to physical, psychological or sexual abuse; work underground, under water, at dangerous heights, or in confined spaces; work with dangerous machinery or tools, or which involves heavy loads; work in an unhealthy environment which may expose children to hazardous substances, temperatures, noise or vibrations; and work under particularly difficult conditions such as long working hours, during the night, or where a child is confined to the premises of the employer.

In Kenya, the Ministry of Labour and Human Resource Development prevents and controls the *worst forms of child labour* by enforcing subsidiary legislation (rules) under section 55 (1998) of the Factories and Other Places of Work Act (Cap. 514 of the laws of Kenya). In particular, the rules prohibit hazardous child labour/work by stating that "No child shall enter into a contract of employment, hired, or voluntary work in occupations which present hazard(s) or are detrimental to the child's safety, health or morals."

In enforcing these rules, inspection officials from the Ministry have found some children working in hazardous situations, characterised by: harsh environments in sisal, coffee and tea estates, fishing and horticultural farms where they were exposed to toxic substances; lack of protective clothing in sisal estates, manufacturing, and mining and quarrying activities within the informal or "Jua Kali" sector; and in the salt mining firms; children being a source of cheap labour in all the sectors they were found; carriage of heavy loads in sisal estates, sand harvesting, stone cutting, salt harvesting, and horticultural farms;

The International Labour Organization approximates that about 250 million children worldwide are involved in child labour, with most children working under harmful conditions; that is in circumstances that are detrimental to their physical, moral, and intellectual development. In Kenya, it is estimated that 2.3 million children (29%) of the 7.9 million children aged 6-14 years in 1999 did not attend school (GoK, 2001) while 1.2 million children in the same age group were involved in child labour. The working children are employed in the tourism and service sectors, plantations, manufacturing, domestic services and in urban informal sector occupations. They are at risk from commercial sex exploitation, hazardous chemicals, physical injuries and sexual and psycho-social abuse. The number of Nairobi's street children, for example, is more than 50,000 and these children are often involved in theft, drug trafficking, assault, trespass, and property damage. The Kenya Government is committed to eliminating child labour and such commitments are stated in various Government policy documents, national legislations, international conventions protecting children, and the UN charter on the rights of children which was adopted by the UN Assembly in 1989 and to which Kenya is a signatory. Despite these commitments, child labour still persists and is prevalent in the country. Various policy measures have been developed to address the problem of child labour and these recognize child labour as being particularly harmful to Kenya's long-term development and to its industrialization prospects in terms of lowered long-term productivity. Currently, Kenya has about 65 statutes that touch on various aspects of children.

The main causes of child labour in Kenya include family violence, HIV/AIDS pandemic, a declining economy, and rapid rural-to-urban migration. Others are the declining gross primary school enrolment rate, intra-ethnic violence, cattle rustling, banditry and severe poverty in some regions of the country.

2.3. HIV/AIDS and the Emergence of Child Headed Households

Sub-Saharan Africa continues to bear the brunt of the global epidemic. Two thirds (63%) of all adults and children with HIV globally live in Sub-Saharan Africa. Promising developments have been seen in recent years in global efforts to address the AIDS

epidemic, including increased access to effective treatment and prevention programmes. However, the number of people living with HIV continues to grow, as does the number of deaths due to AIDS. A total of 39.5 million people were living with HIV in 2006 (UNAIDS 2006)

One of the worst consequences of AIDS deaths is an increase in the number of orphans. HIV/AIDS is the most serious of Africa's many public health problems, as it differs from other traditional public health challenges. The epidemic continues to expand affecting both adults and children, resulting in unique social and economic consequences. World wide, it is estimated that about 22 million people have died of AIDS; 36 million are currently infected with HIV and out of these, approximately 70% live in sub-Saharan Africa. While the impact of this loss of life differs across families, communities and societies, one thing is clear: a child's life often falls apart when he or she loses a parent. (UNAIDS 2006).

There are many AIDS-orphans living on the streets of African countries, and for every child orphaned by AIDS, there are several others about to be orphaned, nursing ill parents, and already acting as primary carers of younger siblings. AIDS-affected children include orphans and children whose parents are ill or too busy caring for ill family members. Many suffer the isolation of fear surrounding the virus, hiding the secret of HIV in the family in case they are shunned by friends and neighbours. Even before they actually become orphans, children are effectively 'growing up alone' because of the shame and stigma which surrounds the disease. (UNICEF, 1999.)

Increasing number of children are living with sick or dying parents or in households that have taken in orphans. Moreover, the pandemic is deepening poverty in entire communities, with children usually the first to suffer from the deprivation. AIDS threatens children's lives. The impacts of AIDS on children are both complex and multifaceted. Children suffer psychosocial distress and increasing material hardship due to AIDS. They may be pressed into service to care for ill and dying parents, required to drop out of school to help with farm or household work, or experience declining access to

food and health services. Many are at risk of exclusion, abuse, discrimination, and stigma. (UNAIDS 2002).

The socio-economic consequences of the HIV/AIDS epidemic are felt in a growing number of countries. Increasing mortality rates among adults are threatening economic and social well-being. Women and children are bearing the heavy burden of nursing the sick and managing households with over-stretched resources.

HIV/AIDS is rapidly increasing the number of orphans who have lost both parents, particularly in Sub-Saharan Africa. The death of one parent at a young age usually does not imply that the other parent will die soon. With AIDS, however, if one parent is infected with HIV, the probability that the spouse is HIV-positive is quite high. This means a child could lose both parents in a relatively short period of time.

The social and economic impact of AIDS threatens the well-being and security of millions of children worldwide. As parents and other family members become ill, children take on greater responsibility for income generation, food production, and care of family members. They face decreased access to adequate nutrition, basic health care, housing and clothing. Fewer families can afford to send their children to school, with young girls at particular risk of being denied an education. In both urban and rural areas, many orphans are struggling to survive on their own in child-headed households. (UNAIDS 2002).

Many AIDS Orphans in Nairobi Slums have to face a life without either parents, or a supportive family. (NACC 2005). Many of the orphans will end up in child headed households and those who go to grandparents will still be given most of the responsibility for bringing up their younger brothers and sisters. (UNICEF, 1999).

The Government of Kenya introduced free primary education in 1997.Despite the availability of free primary education, some households took children out of school to care for members with AIDS and to fulfill mothers' roles. Even if children were not

withdrawn from school, their education was often interrupted by poverty and the need to attend to members with AIDS. Children without appropriate school uniforms, shoes and socks were sent back home. Some children are forced to care for members with AIDS when they are bed-ridden. One child in Kibera slums had to attend to a nearly blind mother with AIDS by assisting with her walking. (UNICEF, 1997.)

Most parents, even if they are aware of their terminal illness, do not attempt to make any alternative living arrangements for their children before their death. Children are left in the household with limited, or no, resources. Women and girls of all ages are shouldering much of the burden of the orphan crisis. Young girls may drop out of school to tend to ailing parents, look after household duties, or care for younger siblings.

Child-headed households have been observed in parts of Africa which have been badly affected by AIDS. They are a new thing in those areas. Most child-headed households are composed of families where both parents have died. Cause of death is not always known but HIV/AIDS is likely to be the cause in most cases.

Durkheim, in his major work division of labour in society presented an analysis of social change arguing that the advent of the industrial error meant the emergence of a new type of solidarity. He highlighted the characteristic of mechanic and organic solidarity as forms of division of labour which reflects the withering ties of today's society (Giddens, 2006). In his argument, He observed that the societies characterized by organic solidarity are held together by people's economic interdependent and their recognition of the importance of others contribution. As the division of labour expands, people become increasingly dependent upon one another, because each person needs goods and services that those in other occupations supply.

Child-headed households face a wide range of issues. The most pressing relate to survival needs and poverty Children and young people in child-headed households need to work hard to care for each other and to earn a living. They may miss out on education and

health care. They may have to cope with grief, stigma and discrimination. These children receive little or no support from the community (***www.ovcsupport.net***).

As the HIV epidemic continues to ravage Sub-Saharan Africa, more challenges start emerging, which have significant effects on child survival growth and development. More catastrophically than elsewhere, the HIV/AIDS epidemic has deepened poverty and exacerbated myriad deprivations in sub-Saharan Africa. The responsibility of caring for orphaned children is a major factor in pushing many extended families beyond their ability to cope. With the number of children that require protection and support soaring – and ever-larger numbers of adults falling sick with HIV/AIDS – many extended family networks have simply been overwhelmed. Many countries are experiencing large increases in the number of families headed by women and grandparents; these households are often progressively unable to adequately provide for children in their care (Africa's orphaned generation, UNICEF, 2003).

HIV/AIDS has had a profound impact on Kenya and other African countries. The African extended family system that could have absorbed children orphaned by AIDS is unable to do so due to the rising levels of poverty. Poverty has eroded the capacity of Kenyan families to take up additional children and responsibilities. Prior to the AIDS epidemic, approximately 6% of the children under the age of 15 years in East Africa were orphans. These orphans were cared for by the extended family members, and when the need arose, community members came together to assist. However, the explosive spread of AIDS over the past 2 decades has contributed to a doubling in number of orphans.

For countries like Kenya that have had long and severe epidemics, AIDS is generating orphans so quickly that conventional orphan care systems can no longer cope. Yet through the accompanying waves of impoverishment and social disintegration, it also destroys the very social fabric necessary for absorbing the growing number of orphans. This two-pronged effect of the HIV/AIDS scourge, it can be emphasized is directly responsible for the emergence of Child Headed Households.

World Health Organization (2005) describes the HIV/AIDS situation in Kenya as a vicious circle. The report says that when parents die, in most cases the living relatives are not willing or are unable to provide care to the orphans. Child headed households have sprung up, and child labour has hit an all time high. They will be found roaming the streets, if they are not being trafficked for sex. This situation puts children at many kinds of risks, including the risk of HIV/AIDS transmission.

2.4. Weakening Extended family ties

The family institution has experienced changes over time. Prior to industrialization, the family was deeply embedded in a broad set of kinship relations (the extended family) and was the hub of economic production The transition to an industrial society, however, in which the family is no longer, as such, a unit of production, dissolved the extended family (Giddens, 2006.). Giddens goes on to say that the kinship relations became pared down to the "nuclear family" which means the family is composed of the parental couple and their immediate offspring.

Parsons *et al* in the book *Family, Socialization and Interaction Processes*, says that the family has become a more specialized agency than before. There is consensus that the family unit is very important in the contemporary society. The nuclear family is said to be the unit responsible for procreation and upbringing of children. This unit is also the main source of emotional support and satisfaction for its members.

Urbanization is the main feature of modern societies that cities created a break with society's natural situation. It has rendered ties of kinship less important and has been substituted with instrumental, transitory and superficial character. The city is increasingly becoming the dwelling place and workshop of modern man. It initiates and controls economic, political and cultural life. It has brought together diverse people, cultures and activities into a cosmos.

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. In contention with the above observation, Giddens (2006) highlighted the characteristic of mechanic and organic solidarity as forms of division of labour which reflects the withering ties of today's society. In his argument, Giddens observed that the societies characterized by organic solidarity are held together by people's economic interdependent and their recognition of the importance of others contribution. As the division of labour expands, people become increasingly dependent upon one another, because each person needs goods and services that those in other occupations supply.

In the contemporary society, 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. This has lessened the ability of older people to exert social control over the younger generation. Bride price is nowadays often a cash payment given to the bride's family, rather than cattle and other possessions raised by members of his extended family; thus marriage itself has become more of a contract between two individuals leading to weaker links between and within extended families (Foster, 1997).

2.5. Child-Headed Households

A child-headed household is one which is led by a child under the age of 18. This child takes on responsibilities usually carried out by parents, including providing care to other children. Children as young as 8 years act as heads of such households. The main event that leads to establishment of a child-headed household is the death of both parents. However, in some cases, one or both parents are still alive. Other events include parental illness or disability. In some cases, one or both parents have left the family home for some reason. The term is usually applied to households where the person heading it is not

the parent. Although there are many documents about teenage pregnancy, this does not appear to have been identified as a factor in causing the establishment of child-headed households.

In some cases, adults do live within households which are child-headed. However, they play no part in providing care for the household and do not contribute to its livelihood. This may be due, for example, to disability or illness. Such households are called 'accompanied' child-headed households. This is distinct from 'unaccompanied' households which have no adults in them.

2.6. Challenges of children in child headed households

Children in CHH face a higher risk of not going to school or leaving school early. Those who go may spend less quality time in school. This is attributed to the lack of money to pay school fees, and time spent taking care of a sick parent and younger sibling. To them education may not be a priority since other basic needs are given first priority. Girls in such households are even more vulnerable they may leave school earlier to take care of their siblings either through getting employment or engaging in sex work (Tolfree, 2004).Therefore the survival of children in CHH may depend on the gender composition of the household. In this case, does gender make a difference in survival?

The disadvantage of having to fend for themselves puts these children at a higher risk of being sexually abused by neighbours and relatives with a promise of offering help and support. When the going gets tough at home, there is a likelihood of them pursuing life on the streets. As a result of this the children are exposed to the dangers of drug abuse which predisposes them to sexually transmitted diseases and HIV/AIDS itself. In worst-case scenarios, orphaned children may be abducted and enrolled as child soldiers or driven to hard labour, sex work, or life on the streets.

Children living in child-headed households may struggle to get births registered. This is due to the fact that information about their birth dates and place is needed and they may not have it. Getting identification cards is also very difficult for them as they may be required to give their birth certificates which they may not have.

In Kenya, rules of inheritance in customary law make children vulnerable to being dispossessed of their property. 'Property grabbing' by families and communities who seize the land, cattle, and other assets when household heads die, is a very common occurrence.

Focusing only on the practical issues can sometimes hide the less obvious deprivations and needs of children growing up in child-headed households. These include the psychological trauma of observing a parent's terminal illness, of dealing with death, the absence of adult guidance and mentoring, and the need for love and security. Children in these settings worry about the future. Lack of parental nurturing. Denial, fear and stigma compound the stress within these families especially if the parents died of HIV/AIDS. This elevated degree of anxiety may trigger behavior problems such as aggression or emotional withdrawal.

Many of these children experience depression, anger, guilt and fear for their futures. This experience can lead to serious psychological problems such as post-traumatic stress syndrome, alcohol and drug abuse, aggression, and even suicide (Foster, 2002).

Poverty and social dislocation also add to their emotional distress. Factors such as loss of household incomes, the cost of treating HIV-related illnesses, and funeral expenses frequently leave these children destitute. A parent's death also deprives them of the learning and values they need to become socially knowledgeable and economically productive adults. Recent research suggests that this breakdown in intergenerational knowledge may play a part in a country's economic decline.

According to UNAIDS, stigma and discrimination continue to accompany the HIV/AIDS epidemic. Children are not immune from stigmatization. In cases of stigma, children tend to be rejected as early as their parents fall ill with AIDS. Some children may be teased because their parents have AIDS, while others may lose their friends because it is

assumed that proximity can spread the virus. (UNAIDS, 2002.) Harsh cases of discrimination have been reported in many countries, including India particularly for HIV-infected children. UNAIDS study found out that HIV-related stigma is particularly high in India, where 36% of the respondents in a survey felt that HIV-positive people should kill themselves, and the same percentage felt they deserved their fate. Another 34% reported that they would not associate with an HIV-infected person. (UNAIDS & WHO, 2004.)

Children who are orphaned by AIDS often have a lower performance in school than children who are not. The preoccupation with the illness or death of their parents, the isolation due to the loss of friends, and the undertaking of additional work that comes with caring for ill parents or supporting oneself after one's parents have died often make it difficult for orphaned children to concentrate in school. (UNAIDS, 2001).

AIDS orphans are particularly vulnerable to violence and abuse. Access to medical treatment can also be very difficult for such children. Orphaned children who live with non-parent guardians may face violations of property rights, labour exploitation, sexual harassment, abuse, and violence. (UNAIDS & WHO, 2003).

Children who are solely responsible for their siblings struggle not only to support the household, but also to keep their homes. Property grabbing is a practice where relatives of the deceased come and claim the land and other property, is reportedly a serious problem for widows and child-headed households in Kenya.

Traditional law in many rural areas dictates that women and children cannot inherit property. (Makame et al, 2002.) Property grabbing has a number of negative consequences particularly for girls and women. Girls may experience sexual abuse and exploitation from their new caretakers, girls and women may be forced into the sex trade in exchange for shelter and protection, further increasing the risk of contracting HIV. Some are concerned that the practice of property grabbing heightens the strain on extended families and increase the number of street children. (Gebalie & Gruendel,

1998.) Kenyan inheritance law provides children with important protections when both parents die without leaving a will, their property is to be divided equally among their children, whether male or female. If the child is under 18, a public trustee will administer the property until the court appoints a person who administers the property on the child's behalf this may be the guardian or any other adult (Law of Succession Act, 1981). However, this is not the reality because many children in Kenya do not inherit the property they are entitled to from their deceased parents. Cases of property grabbing are very common among orphans and widows. To orphans in child headed households in particular this can mean denial of basic social and economic rights, including the right to health and education.

Children rarely know their rights, how to get a lawyer, or how to access the Office of the Public Trustee. In many cases, surviving relatives grab the property they are meant to administer for the child, in other cases, relatives seeking to safeguard a child's inheritance face numerous bureaucratic obstacles. Sometimes children are chased away from their parent's property. (Geballe & Gruendel, 1998.) Some families strip children off their property and then place them at the orphanage. when children demand their inheritance their relatives sometimes react with threats (Human Right Watch 2007).

2.7. Why children choose to stay alone in child headed households

It is widely stated that the creation of child-headed households is evidence that the extended family system is unable to cope with situations created by HIV/AIDS. Child headed households may also be a mechanism by extended families to cope with the situation. Some child-headed households live close to their extended families. They may receive limited amounts of material support. In some situations, younger children (under 5 years) are taken to live with the extended family. The older children and young people are kept together within a child-headed household.

Various reasons are given for children and young people living in a child-headed household rather than with the extended family. This may be because no relative could be identified to take them. Alternatively, it may reflect the wishes of the parent and/or the

children. Many parents and children prefer to live as a child-headed household rather than to risk loss of the family home and other property. In addition, children and young people often wish to stay together. This is not always possible if care of children is taken on by extended family members.

2.8. Girl Children as Heads of Households

Girl children are especially vulnerable in the context of HIV/AIDS and the emergence of child-headed households. Gender-based discrimination, which often leads to the sexual division of labour, means that girls are more likely than boys to have to care for terminally ill family members. This deprives them of the right to education, and often means they have to do tasks that affect their right to not be subjected to child labour. Orphaned girl children are especially vulnerable to being victims of sexual exploitation and trafficking. Due to cultural attitudes and taboos concerning any sexual activity by girls, they may have little access to preventive measures and other services (Nielsen 2004).

2.9. Children's rights in relation to child headed households

Children affected by HIV/AIDS are vulnerable long before their parents die. Girls, in particular, assume caring responsibilities for their ailing parents besides parenting for their siblings. With the weakening extended family systems in our society most children find themselves without proper social support with the incapacitation and death of their parents. This would deny the OVC a chance to access their basic needs such as proper health care, education shelter and nutrition. Orphans suffer stigma, stress and trauma in addition to the loss of parental love, care and protection and more often they are disinherited (http://www.olf.org.za/ovc-in-Kenya).

2.10. The Convention on the Rights of the Child (UN-CRC)

The UN Convention on the Rights of the Child, adopted by the United Nations in 1989, is the most important international treaty dealing with all aspects of children's rights. It provides a useful framework for addressing the rights of children in child-headed households. The document aims to: promote the protection of children; encourage their

participation in society especially in matters that affect them; prevent harm being done to children; and provide assistance to ensure children's basic needs are met.

Concerning policy considerations that are specific to child-headed households, the General Comment number 3 underlines the need for legal, economic and social protection for affected children. The focus should be on access to education, access to shelter, access to state benefits such as social grants, and access to health care services, as well as fair inheritance rights. Acquiring proof of identity has very important implications for a child, because it relates to securing his or her recognition as a person before the law. The General Comment draws attention to this. Proof of identity also helps to protect other rights, including inheritance rights and the right to education. The philosophy of the Committee is that orphans are best protected and cared for when siblings can stay together, in the care of relatives or family members, or the extended family. If the extended family has been destroyed by HIV/AIDS, the state must then provide, as far as possible, family-type alternative care, such as foster care. Institutional care should play only an interim role in caring for children orphaned by HIV/AIDS, and only when family or community based care is not available or feasible. The General Comment reminds State Parties that there must be limits on the length of time that children spend in institutions. The main goal must be to eventually reintegrate them into communities. The General Comment acknowledges formally that child-headed households now exist. States Parties are encouraged to provide financial and other support to them. As a matter of policy, though, the General Comment says that communities are the frontline of the response to HIV/AIDS and other related consequences, such as child headed households. States' strategies must be designed to support them in deciding how they can best provide support to the orphans living in their communities ***(Nielsen 2004)***.

Because HIV/AIDS so often impoverishes and stigmatizes the children it affects, and claims the lives of so many in their extended family, these children are at high risk of having to eke out livelihoods on the street or in other potentially dangerous situations. AIDS-affected children face many obstacles to staying in school and thus to fulfilling their right to education. They are further disadvantaged in many cases by the

unscrupulous and unlawful appropriation of property they are entitled to inherit from their parents, and in Kenya they are rarely able to take legal action to protect their inheritance rights. These factors together place at risk the realization by AIDS-affected children of their right to survival and development, which the government has an obligation to ensure "to the maximum extent possible" under the United Nations Convention on the Rights of the Child. These problems are compounded in Kenya by apparently poor access of children and young adults to appropriate and clear information about HIV/AIDS, which puts children at risk of being unable to protect themselves from HIV transmission. Children have the right to survival; physical, social and cultural development; health; and education. These rights are guaranteed under the Convention on the Rights of the Child, the International Covenant on Civil and Political Rights, especially article 24, and the African Charters on Human and Peoples' Rights and on the Rights and Welfare of the Child, all of which Kenya has ratified.

Kenya needs to strengthen protections of the rights of AIDS-affected children. Governments around the world have neglected the consequences of AIDS on children and have failed to provide the necessary protections of their rights to survival and development. This failure is one of the most pervasive and lasting crises of the HIV/AIDS catastrophe and it must be addressed with the greatest urgency (Human Rights Watch, 2001).

2.11. The African Charter on the Rights and Welfare of the Child (1990)

Kenya ratified the African Charter on the Rights and Welfare of the Child in 1990. It defines a child as any human being under the age of 18 years. The Charter says that all children either boys or girls have the same rights. It is an important regional charter for protecting and promoting children's rights. The Charter has outlined various rights that every child is entitled to, these include: The right to a name and identity, the right not to be discriminated because of a child's race, religion, race, disability, language or ethnic group. According to the Charter children have a right to be cared and protected by their parents, a right to good health, a right to be protected against drug abuse and the right to

education. Children are entitled to freedom of expression and freedom from being separated from parents.

The Charter reinforces States' obligation to ensure, to the maximum extent possible, children's survival, protection and development (Article 5), while recognizing that the family is the "natural unit and basis of society" (Article 18). The Charter specifically says that States "shall ensure that any child who is parentless, or who is temporarily or permanently deprived of his or her family environment...shall be provided with alternative family care, which could include, among others, foster placement or placement in suitable institutions for the care of children" (Article 25(2)).

It is largely silent on the specific issue of HIV/AIDS and child-headed households, as it was also drafted before the enormity and scale of the pandemic was fully realized.

2.12. The Children's Act

The **Children's Act Cap 586** is a law enacted to promote the well being of children in Kenya. The act is a merger of the repealed Guardianship of Infants Act, Adoption Act and Young Person's Act, which have been harmonized and updated. The Act addresses the rights a child is entitled to and the role of the government and parents in protecting these rights. The act also sets out the general roles and responsibilities of parents in ensuring the wellbeing of the child. It provides for the establishment of institutions dealing with children and gives the guidelines on issues of children's welfare, legal aid, custody and care of children, foster care, guardianship and adoption.

The Children's Act provides for the rights of all children as are provided for in the CRC and the African Charter.

The Act stipulates that every child has the following rights;- inherent right to life, right to parental care, right to education ,right to religious education, right to health care, protection from child labour and armed conflict, children should also not be recruited in armed conflict or take part in hostilities, right to name and nationality, right of children with disabilities to be treated with dignity, protection from child abuse, protection form

harmful cultural rites, protection from the sexual exploitation, protection from drugs, leisure and recreation, torture and deprivation of liberty and right to privacy.

These rights are to be practiced with the following principles:

Best interests Principle - In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of children shall be a primary consideration. ***Non Discrimination*** - No child shall be subjected to discrimination on grounds of origin, sex, religion, creed, custom, language, opinion, conscience, colour, birth, social, political, economic or other status, race, disability, tribe residence or local connection.

The Child's Opinion - When working with children, it is always important to allow the child to air their views or opinions on an issue and also to ensure that the views or opinions are respected and given due weight.

Maximum Survival and Development - All actions affecting children should be directed in ensuring that their lives are protected and that they develop in the best possible way.

Despite these protections, children continue to suffer human rights abuses in Kenya today. Although the government and donors are involved in a multitude of protection activities, child protection systems are weak in Kenya, and children who experience neglect or abuse are often left with no one to turn to; they are also at heightened risk of HIV infection as a result. Children whose parents are terminally ill drop out of school to act as caregivers to their parents and younger siblings (Human Rights Watch, 2005).

2.13. Kenya OVC Action Plan 2007-2010

This is the Government of Kenya's National Plan of Action on Orphans and Vulnerable Children (OVC). The Ministry of Gender, Children and Social Development, through the Department of Children Services, found it necessary to develop this document as a response to the ever increasing orphans and vulnerable children country wide. The aim of the plan is to strengthen the capacity of families to protect and care for OVC, provide economic, psychosocial and other forms of social support, as well as mobilize and

support community based responses to increase OVC access to essential services such as food and nutrition, education, health care, housing, water and sanitation. The Department of Children Services, within the Ministry of Gender, Children and Social Development, in collaboration with the National Steering Committee on OVC developed the OVC Policy, a key aspect of which is the provision of a direct predictable and regular cash subsidy of KSH 1,500 per month to households caring for OVC(Department of children's services 2007).

It was estimated that by 2005, the number of orphans was 2.4 million, 48% of these being as a result of HIV/AIDS. This figure is besides a higher number of children rendered vulnerable by poverty, emergencies, insecurity, amidst other factors. The Government and other stakeholders have come up with several interventions to address the problem of OVC but this has remained inadequate in the face of the increasing number of OVC.

HIV/AIDS scourge compounded with high poverty levels and the recent post election violence have aggravated the situation of OVC in Kenya. The above situation exposes the orphans and vulnerable children to different forms of abuse and exploitation; physical abuse, defilement, sexual exploitation, child labour, and early marriages while more flock to streets to fend for themselves. This situation diminishes their capacity to participate in matters affecting their life. The above is in contravention of the rights of the children.

The Government of Kenya and other stakeholders are coming up with a number of interventions in an effort to address the situation of OVC in the country. However, many remain unreached.

Through the National Plan of Action for OVC the Kenyan Government has identified the following Priority Strategic Areas as key for OVC interventions: Strengthen the capacity of families to protect and care for OVC, Mobilize and support community based responses, Ensure access for OVC to essential services including but not limited to education, health care, birth registration, psychosocial support and legal protection, to ensure improved policy and legislation are put in place to protect the most vulnerable children, Create a supportive environment for children and families affected by

HIV/AIDS, Strengthen and support national coordination and institutional structures and Strengthen national capacity to monitor and evaluate programme effectiveness and quality.

In this regard, the National Plan of Action for OVC spells a minimum package for OVC support that is age oriented. This is in recognition that OVC are not a homogenous population but like other children, their needs change with their physical, emotional and mental growth. Through the Area Advisory Council, the Government has a responsibility to ensure that the plight of orphans is not exploited by unscrupulous persons/ institutions that purport to be providing support to OVC but end up enriching themselves or abusing the orphans. The community also has a primary role in safeguarding the rights of orphans in their midst. The Government through Department of Children Services with support from Development Partners is implementing a Cash Transfer Programme for Orphans and Vulnerable Children (CT-OVC) to extremely poor households taking care of OVC. This is a social protection intervention which provides regular and predictable cash transfers to these extremely poor families in order to encourage fostering and retention of OVC within their families and promote their human capital development. The programme is being implemented in some locations of 47 old administrative districts and is currently covering 45,815 households. The existing Area Advisory Councils (AACS) have been further strengthened to take up the responsibilities of this programme at the districts levels. The future scale-up of this programme would be dependent on the availability of more funds from both the government and development partners.

An OVC Secretariat has been established at the Department of Children's Services Headquarters to enhance coordination of OVC initiatives in the country. A multi-sectoral National Steering Committee on OVC was established in 2004 to provide policy guidance on OVC interventions. The Government has developed Child Adoption Regulations to streamline the adoption procedures and protect the rights of adopted children. Likewise, Charitable Children Institutions Regulations (CCI) have a gazzeted legal framework which guides the establishment and management of these institutions that cater for orphans and other vulnerable children. There are other government ministries that have services that target all children including the OVC such as in health

and education. However there is need for these service/ programmes to take care of the vulnerability and the special needs of the orphans. In this regard a heightened intervention at the school level is highly recommended to ensure increased school enrolment, attendance and retention for the OVC. The government recognizes and appreciates efforts made by development partners, non-governmental organizations, and civil society organizations; community based organizations and faith based organizations in providing support to OVC in the country.

2.14. Theoretical Framework

A theory is a set of interrelated constructs, definitions and propositions that present a systematic view of phenomenon by specifying relations among variables, with the purpose of explaining and predicting the phenomena (Kerlinger, 1964). A theory provides the basis for establishing the hypotheses to be tested in the study (Mugenda and Mugenda, 2003).

2.14.1. Structural Functionalism

Structural functionalism is simply a synonym for explicit scientific analysis. As an occupational role, the term function may refer to specialised activity, duties, work or a set of official roles assigned to public functionary for example function of a clerk, teacher, nurse etc. It may also mean an appropriate and sustaining activity or part played by a unit within the context of a larger whole. It refers to positive and negative consequences of social institutions and processes.

Structural functionalism is a view of society as a self-regulating system of interrelated elements with structured social relationships and observed regularities. It is a sociological perspective which seeks to explain a social element or cultural pattern in terms of its consequences for different elements as well as for the system as a whole. It stresses the integrative role of structures in society, enabling it to keep a social equilibrium. It emphasizes structures over individual actors. As bearers of social or political functions, structures were typically seen as having a life of their own. Some of the tenets of this school of thought are Auguste Comte, Herbert Spenser, Emile Durkheim, Tarcott Parson, Radcliffe-Brown and Merton.

One of the most important characteristics of society is its systemic nature. He argues that a society is system of interrelated parts, something more than just the mere individuals within it. He says that a society is an interdependent system. He views society as a functionally organised system with its components living in harmony. He says that the society is always at equilibrium, and the actors will always try to maintain this balance.

Herbert Spenser compares a society to an organism suggesting that a society can be seen as an organism which grows in size, the increase in size leads to complexity and differentiation, progressive differentiation of structures accompanied by both progressive in function. Parts of both organisms are mutually interdependent and death in one is followed by death in the part. The proponents of this theory say that, the parts of a society are what today called its institutions. These include the family and kinship system, the political system, the military, religion, forms of social control and so on.

It is further argued that societies are assumed to be in equilibrium or orderly or in a stable condition until some event or change occurs. When this happens, it is assumed that societies produce more changes as part of a process of adaptation to the new situation in order to re-establish equilibrium.

This theory is very applicable to my study. The emergency of CHH can be argued as a result of some disturbance or change in the family institution. The extended family was at equilibrium until the HIV scourge which in my view has destabilized the extended family as a system. This has led to the system adapting through having CHH in order to re-establish equilibrium. The extended family tends to be accepting this new phenomenon as there is evidence of some of the CHH receiving support from the extended families.

Radcliff Brown also talks about social conjunction and social disjunction. According to him, social disjunction implies divergence of interests and possibility of conflict, while conjunction requires stability and avoidance of strife. Abrahamson on the hand emphasizes the fact that society experiences conflict, disorder and change. This can be said of the emergency of the CHH phenomenon. It can be urged it is as result of disorder

in the extended family and also as result of its changing nature. Merton argues that while it is possible to have a standardised social and cultural believes in small and primitive societies, this is not possible in the modern society because of social change.

2.14.2. Social Systems Theory

The social system consists of units of individual actors and their interaction patterns that contribute to structural development or change (Parsons; 1967).

There are three types of social systems- namely, groups which include the family, organization, the community; social category systems, which include sex and age, social class, ethnic groups, ecology and demography; while the institution includes economic system, religion, science and education, the political system.

The social systems are not static; they are in constant interchange with their environment. All three types of social system include elements of social systems- namely, values, norms and interaction patterns (Parsons; 1967).

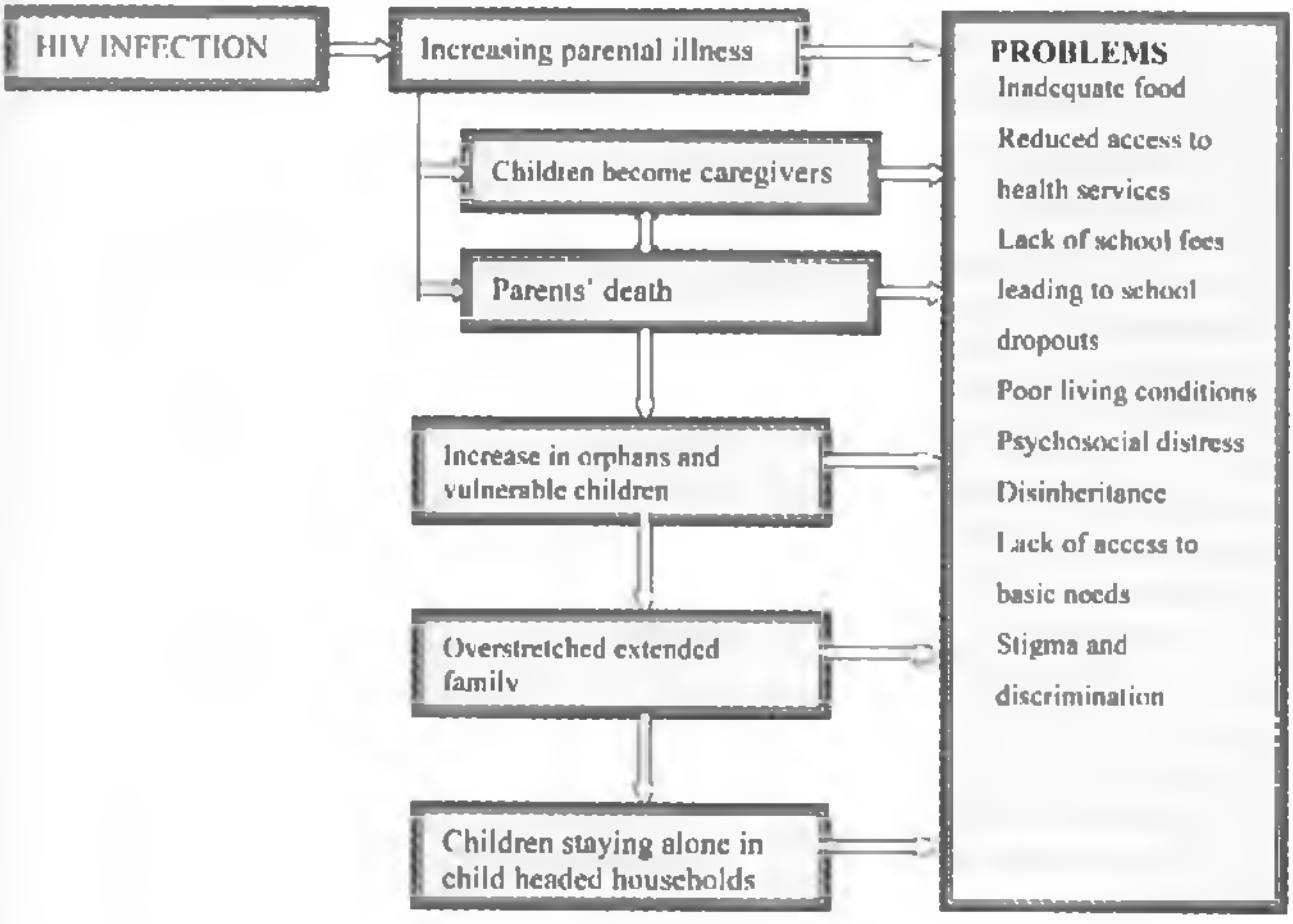
In order to maintain itself, the social system must do the following;

1. Satisfy at least the minimal needs of a sufficient proportion of the population.
2. Acquire at least a minimum amount of support and motivation from members so that needed tasks and roles can be fulfilled; and
3. Provide for the production of at least adequate cultural resources.

As a social system becomes more complex in size, segmentation and differentiation, it faces some kind of functional problems such as allocation of resources and facilities. Because the demand for gratification is greater than the available resources and supplies, everyone cannot get all he would prefer. This is true of the extended family having constraints because of the enormous numbers of orphans the society all competing for the limited resources within the extended family. If this functional problem is not resolved adequately, it could lead to the replacement of the existing social system by a new one. It is quite evident that the problem has not been dealt with adequately hence the emergence

of CHH which is threatening to replace the existing extended family structure with one where children can live on their own and be recognized as a family unit. When a new social system replaces the old social system, it causes displacement of members of the society and alters their position in relation to the new system. This implies that the major cause for the emergence of CHH, particularly in Africa, is as result of replacement of old social system where the extended family took care of orphaned children by a new one where children are living on their own.

2.15. Conceptual Framework



CHAPTER THREE

METHODOLOGY

3.1. Introduction

This section describes the methods that the researcher used to collect, analyze and present data. The section includes: - area of study, target population, sampling technique and sample size, data collection tools and techniques.

3.2. Area of Study/Site description

The area of study is Kibera slum of Nairobi Kenya. The 2009 Kenya Population and Housing Census reported Kibera's population as 170,070. The large size of the slum will ensure that the research gets the required sample of children in child headed households.

Kibera's history goes back to 'colonial period' when the urban layout was based on government-sanctioned population. This was the era of racial segregation that separated people into the enclaves for Africans, Asians and Europeans. As an informal settlement, Kibera dates back to the 1920s' when the British colonial government decided to let a group of Nubian soldiers from Sudan to settle on a wooded hillside outside Nairobi. The British colonials then failed to repatriate the Nubians to their country or to compensate them with land title deeds to these acquired lands from the Kenyan people. Nubians built homes, and set up businesses while they were still squatters with no legal rights and they called the place Kibera, meaning 'forest'. (BBC 2002.)

The 2009 Kenya Population and Housing Census reported Kibera's population as 170,070. In an article by Rasna Warah published in the Daily Nation of October 8th 2010, Kibera slum was previously thought to be one of the biggest informal urban settlements in the world. Rasna says that Kibera is not the biggest slum in Africa. The 2009 Kenya Population and Housing Census shows that one of the world's most famous slums houses just 170,070 residents, not one million, as previously believed. "For a long time Kibera has been touted as Africa's largest slum, with various 'experts' putting its population at anything between one and two million" (Karanja, 2010).

According to the census, seven locations that form Kibera slum combined host a total of 170, 070 residents. These are Lindi – 35,158, Kianda- 29356, Laini Saba- 28,182, Makina- 25,242, Gatwikira – 24,991, Siranga – 17,363, and Kibera- 9,786.

Several actors had provided and published over the years growing estimations of the size of its population, most of them stating that it was the largest slum in Africa with a number of people reaching over 1 million. According to Mike Davis, a well known expert on urban slums, Kibera had a population of about 800,000 people. International Housing Coalition (IHC) talked about more than half a million people. UN-Habitat had released several estimations ranging between 350,000 and 1 million people. These statistics mainly come out of analysis of aerial pictures of the area. IRIN estimated a population density of 2000 residents per hectare.

In 2008 an independent team of researchers began a door-by-door survey named "Map Kibera Project" with the aim to map physical and socio-demographic features of the slum. A trained team of locals, after having developed an ad-hoc surveying methodology, has so far gathered census data of over 15,000 people and completed the mapping of 5000 structures, services (public toilets, schools), and infrastructures (drainage system, water and electricity supply) in the village of Kianda. Looking upon Kianda's collected data, the population of the whole Kibera slum can be estimated between 235,000 and 270,000 people (MSF, 2005).

Kibera is located 5 kilometers South East of Nairobi City Centre and it lies at an altitude of 1,670m above sea level, latitude 36 degrees, 50° east and longitude 1 degree, 17° south about 140 km south of the equator (Karanja et al. 2002.) The growth of Kibera as an informal settlement is closely connected with Nairobi City's phenomenal growth. Life there is a daily struggle with poverty, crime, and diseases. Many Kibera residents work in Nairobi's industrial sector for wages near Ksh. 150 per day. The Kenya to Uganda railway passes through Kibera. Living structures are constructed haphazardly on every available space leaving narrow alleys which serve as open sewers and footpaths. (Karanja, et al. 2002.).

Even though Kibera is not an official settlement people have to pay rent, and this often collides with the decision of rather buying food for that money. For the mud houses, depending on the sizes, people pay in average 500 to 1000 Ksh per month rent. But for a lot of other people even 500Ksh per month can become a big problem. There are a lot of families living in Kibera since generations and they seem to like it there because it is their home.(Mulumba,et al 2004.) Generally Nairobi slums residents have a high unemployment rate and they do depend on the informal sector. The income of slum residents mostly comes from informal economic activities such as hawking food and clothing, although some have formal employment. The residents commonly rely on small-scale trade to make a living, but the majority of such enterprises lack a valid commercial license from the Nairobi City Council. Other common problems in Nairobi slums are that social services to slum dwellers are neglected, high unemployment and livelihood insecurity promoting alcohol and drug abuse.

Toilets and water points in Kibera are public. As many as 400 people can end up sharing one toilet in one of the many privately owned latrines. Kibera perhaps suffers the greatest water shortage in Kenya due to its population. In terms of water sources, Kibera residents rely on hawked water.

There are also over 60,000 AIDS orphans surviving in Kibera, often cared for by grandparents, over crowded orphanages, or completely unattended (Gachuhi, 1999.). For these and other children in Kibera, schooling is rare and inadequate, trapping these youth in a cycle of poverty (www.kslum.org). In Kibera, the prevalence of HIV/AIDS is estimated to be around 15%.

3.3. Site Selection

The study was carried out in four out of seven villages in Kibera. These were Lindi- 35, 158 people, Kianda- 29,358 people, Laini Saba- 28,182 people and Makina 25,242 people. These villages have the highest population of orphans and vulnerable children and also host most orphans support projects.

3.4. Target Population

A target population refers to all the members of a real or hypothetical set of people, events or objects to which we wish to generalize the results of our research. The target population of this study is made up of children under the age of 18 both male and female who head their households or live in child headed households in Kibera slums of Kenya. Children in child headed households were interviewed to provide first hand information about the challenges they face and the strategies they employ to deal with them. Key informants such as social workers from organisation supporting these children, chiefs, teachers and children's officers were also interviewed to give an in-depth understanding of the phenomenon.

3.5. Sample Size

The researcher employed purposive sampling to select the children who participated in the study. A total of 50 children living in child headed household were identified through the Chief's Office and the support organisations for orphans operating in the above villages. Ten key informants were also interviewed to give more insight into the issue of child headed households.

3.6. Sampling

Sampling refers to "the process of selecting a number of individuals for a study in such a way that the individuals selected represents the large group from which they were selected" Mugenda and Mugenda, 2003. The purpose of sampling is to secure a representative group which will enable the researcher to gain information about a population. According to Singleton et al (1998) the sampling design to be adopted depends on several preliminary considerations, one of them being the presence of a sampling frame.

3.6.1. Purposive Sampling

Kerlinger (1986) explained purposive sampling a type of non-probability sampling, which is characterized by the use of judgment and a deliberate effort to obtain representative samples by including typical areas or groups in the sample. In other words, the researcher attempts to do what proportional clustering with randomization

accomplishes by using human judgment and logic. Subjects are selected because of some characteristics they possess.

Purposive sampling was used to identify children in child headed households. Initial subjects with the desired characteristics (children in child headed households) were identified purposively through the chiefs and support organisations in the area. The researcher used a pre existing list of all the orphans in child headed households. This list is maintained by the area chiefs and also the support organisation which they use to provide the various benefits to the orphans. In this list there were 80 children living in child headed households. Out of the 80 the researcher was able to trace 50 with the help of the community health workers who guided me to the children's homes.

3.7. Data Collection Tools and Techniques

According to Mugenda and Mugenda 2003, data refers to all the information collected by a researcher from primary sources through questionnaires, interviews and observation and from secondary sources such as books, records, journals and magazines. Data collection on the other hand is the systematic process through which information on population under inquiry is gathered.

Mugenda and Mugenda, 2003 further says that an interview schedule is, "a set of questions used when interviewing and makes it possible to obtain data required to meet specific objectives of the study". Interview schedules can have structured semi-structured or unstructured questions. In this study the researcher used questionnaires that had both structured and semi-structured questions. Key informant guides were also used

The data collection techniques used were face to face interviews and in- depth discussions.

3.7.1. The Questionnaire

A questionnaire is used to collect data that is descriptive and quantitative in nature. The researcher personally administered the questionnaires to the respondents in this study.

The respondents were assured that strict confidentiality will be maintained when dealing with the responses. The researcher administered questionnaires to 50 children living in child headed households in Kibera slum.

3.7.2. Key Informant Guide

A key informant guide is used to collect qualitative data from key informants. The research held in-depth discussions with key informants based on predetermined questions. The key informants in this study were the teachers where some of the children attend school, social workers, some of the sick parents, chiefs, village elders and children's officers. These people have in-depth information about challenges faced by children in child headed households. The interviews with the key informants were prearranged. Probing was also used to ensure that the researcher gets the right information from the respondents.

3.7.3. Observation

Observation as a data collection technique was also used. Conditions of living for children in child headed households were observed. Their physical outlook was observed which gave a lot of insight about the nutritional and general health status of the children.

3.8. Units of Analysis

According Mugenda and Mugenda, 2003:14, "units of analysis are the individual units about which or whom descriptive or explanatory statements are to be made". In this study therefore the units of analysis were children under the age of 18 years who live in child headed households.

3.9. Data Analysis

The data collected was reviewed, cleaned, coded and recorded into themes. The quantitative data was keyed into a computer using SPSS package while the qualitative data was analysed into the classified themes. From this stage, tables, charts, totals and percentages were used to present and interpret data.

3.10. Ethical Considerations

While any respondent's welfare is important, in a research project where children will be the respondents the researcher has to take extra responsibility to make sure that the experience is a positive one for them. In this particular study the researcher obtained permission from parents (for the few who had a living parent) the guardians such as the

social workers in the support organizations, teachers and the chiefs before interviewing them. The nature of the research was clearly explained to the children who were assured of confidentiality and were free to terminate the interview at any point. They were free not to answer any question they didn't free answering. To make sure that a child is not teased or embarrassed by the peers, the interviews done on a one to one and in private place.

3.11. Limitations

The respondents in this study were children as young as 11 years. This posed a challenge in the authenticity of some of the information I got from them. Due to their age some could not for example remember certain details about the death of their parents. The area of study had been affected by the post election violence, some of the respondents seemed uneasy talking to a stranger. The children being very vulnerable and poor expected some gains after participating in the study.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1. Introduction

This chapter gives findings of the research that was conducted to examine factors surrounding the emergence of child headed households (CHH) and the experiences of children in these households. The study investigated the following; - causes of the emergence of CHH, channels used by children in CHH for survival, source of emotional, material and financial support and challenges faced by these children.

The chapter has been arranged into sections in line with the objectives of the study. The presentation and analysis is in form of tables and charts. Qualitative data has also presented inform of discussions to provide more insight.

4.2. Household characteristics/Background information

4.2.1. Age Composition

Table 1: Age distribution

Age/year	Frequency	Percent
11-15	20	40
16-18	30	60
Total	50	100.0

Majority of the children living in a child headed household were aged between 16- 18 years who accounted for 30 children 60%). Those aged between 11-15 accounted for 20 (40) of the total. Children who had lost both of their parents accounted for 84%. Those living with a sick mother accounted for 13% while those living with sick father accounted for 3%.

4.2.2. Gender Composition

Table 2: Gender distribution

Sex	Frequency	Percent
Male	29	58
Female	21	42
Total	50	100.0

Most of the children interviewed were male. Out of the 50 children interviewed 29(58%) children were males while 21 (42%) were females of which majority of the family heads were boys (73%). This is attributed to the fact that most girls had gone away from home to seek employment as house helps while others got married and the boys were left at home. The boys therefore managed the day to day decisions in the households. It also came out that relatives preferred picking girls than boys when parents died. Girls would be preferred because the host relative would forego the cost of hiring a house help who are usually girls.

4.2.3. Family Size

Diagram 3: Family size

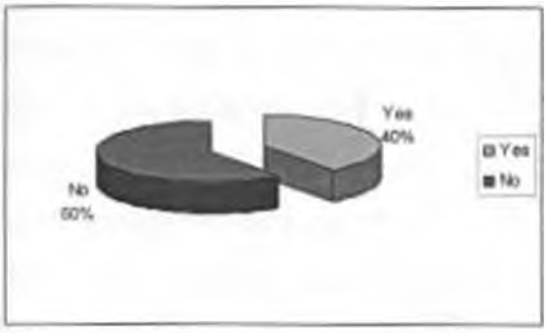
Number of household members	**Frequency**	**Percent**
2-5	35	70
More than 5	15	30
Total	**50**	100.0

The study revealed that most of the child headed households had two to five members which accounted for 35(70%) of the total. Only 15(30%) of the child headed households had five or more members. The small size of households can be attributed to the fact that Kibera is an urban settlement where the rate of family planning is high and also the fact that parents are highly sensitized on the importance of having a small family. The urban influence may have resulted to parents giving birth to few children. Since most of the parents died of HIV related illnesses, they died in the prime reproductive age hence the

small family size. Others may have been deterred from having large families because of their HIV/AIDS related illness.

4.2.4. School attendance by the children

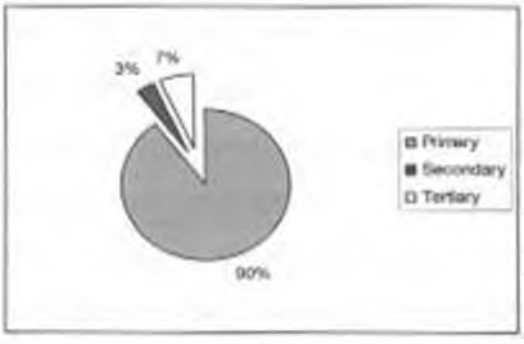
Diagram 4: School attendance



Of the children interviewed, 30(60%) were not attending school while 20(40%) were in school. Those that were not in school had dropped out at primary school level for various reasons. The key informants who were interviewed said that some of these reasons were lack of learning materials, lack of parental moral support and the stigma they faced that is associated with orphan hood due HIV/AIDS. Some had also dropped out school due to the need to work and support the younger siblings. Information from school teachers revealed that most of the orphans are bright children but in most cases their performance was affected by psychological issues. They explained that some of the orphans seemed withdrawn in school and lacked confidence.

4.2.5. The highest level of education attained

Diagram 5: Education levels



The study established that 45 (90%) of all the children interviewed had dropped out of school at primary level. Only 1(3%) had gone up to secondary and 4(7%) had attended

tertiary institutions. Children, especially girls, from AIDS-affected families are often withdrawn from schools to compensate for loss of income through a parent's sickness and related expenses, to care for the home and the sick relatives. These families may also withdrawal their children out of school because they cannot afford school fees

Children in CHH face a higher risk of not going to school or leaving school early. Those who go may spend less quality time in school. This is attributed to lack of money to pay school fees, and time spent taking care of a sick parent and younger sibling. To them education may not be a priority since other basic needs are given first priority.

4.3. The emergence of child headed households

4.3.1. The status of parents of the children in Children Headed Households

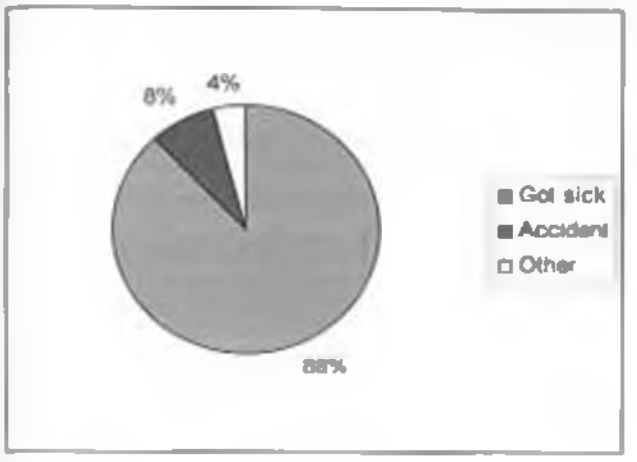
Diagram 6: Parents Status

Parent	Frequency	Percentage
Dead	40	80
Sick	10	20
Total	**50**	**100**

The parents of the children in the households were reported to be sick or dead. Most of the children interviewed were orphaned since 40 (80%) reported that their parents had died. The 10(20%), who lived with their parents, indicated that those parents were sick. The status of parents (constantly ill, if not dead) forces the children to assume adult responsibilities even when parents are still alive because they have no choice than to depend on their children when sick. On demise of their parents, the children automatically take up parenting roles as house heads. Therefore when parents are bedridden or dead roles are reversed where children become heads of households taking care of the parents instead of children depending on them.

4.3.2. Cause of parents' death

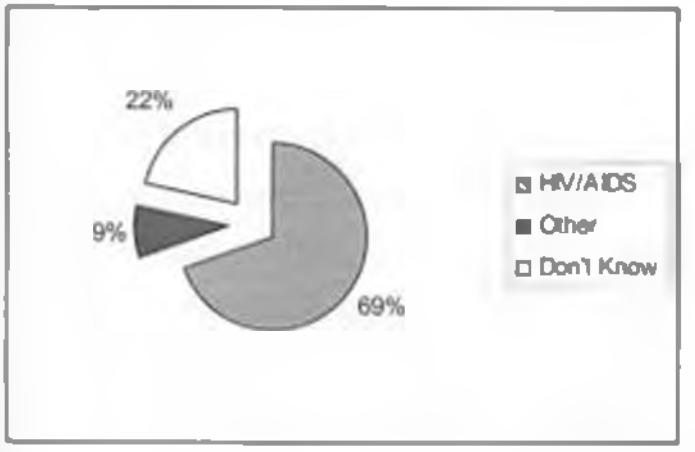
Diagram 7: Cause of death



Of the children whose parents had died, 44(88%) of them reported that the cause of death was sickness, 4 (8%) reported that their parents died out of accidents while 2(4%) indicated that they died out of other causes they were not aware of. Those who indicated that their parents died of other causes said they were too young (aged below 5) at the time their parents died to comprehend.

4.3.3. The nature of parents ailments

Diagram 8: Nature of ailment



The researcher found out that the children aged 16-18 years who were the majority interviewed were old enough to identify the nature of their parent's ailments. Of the

children interviewed, 34(69%) reported that it was HIV/AIDS related illnesses,11 (22%) though did not identify the specific ailment, explained that their parents had died after they got sick and 5(9%)were reported to have died of other causes like accidents.

When the researcher probed further by asking the children to explain the nature of ailment, they described symptoms that included coughing, headaches, diarrhea among others indicative of HIV/ AIDS. The data from key informants also confirmed that most of the parents had died of HIV/AIDS related illnesses. They reported that most of the people in the village are knowledgeable about the symptoms HIV/AIDS and therefore could relate them to the cause of parents' deaths. The key informants also confirmed that most of those parents were members of support groups for people living with HIV.

From the above discussions, it emerged strongly that the main cause of child headed households is HIV and AIDS which is a major contributing factor to orphan hood in the area of study Kibera slum Nairobi.

The major reasons underlying child headed household phenomenon were largely linked to absence of a close relative to take up parenting responsibility. In some cases it also reflected the wishes of the parent and/or the children. Many children also preferred to live as a child-headed household rather than risk loss of the family home and other property. In addition, children often wished to stay together to avoid losing identity and contact with each other.

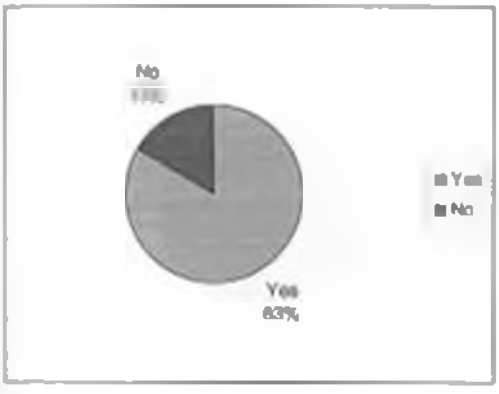
4.4. Challenges faced by children in child headed households

Children in child headed households described financial problems like lack of income and psychosocial problems, social stigma and discrimination as the major problems they face them. In this regard ,the AIDS orphans described that the economic problem arise from income loss due to the death of a parent/guardian from AIDS and it is considered as a major problems hindering them from accessing the basic needs like food ,shelter and clothing as well as the problem of health and education. The financial problems were found to affect the survival of orphans and their families. The study found out that these problems are deterring the orphans from adequate feeding, clothing, schooling, shelter,

health care services thus the livelihood and welfare of these children was highly affected. These children described emotional and psychological challenges which they have to contend with.

4.4.1. Lack of access to basic needs

Diagram 9: Lack of access to needs



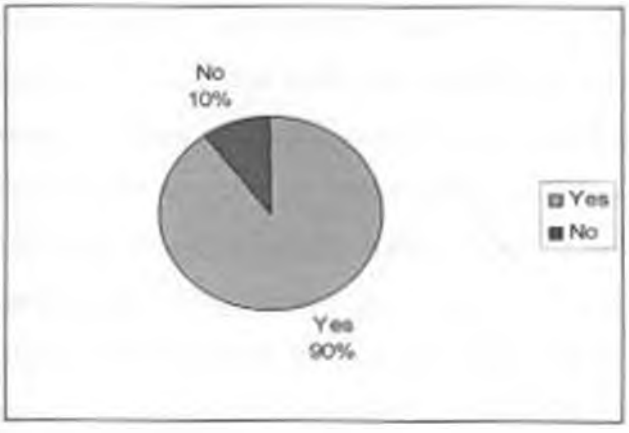
Of the children interviewed, 83% reported having been unable to access basic needs after the death of their parents while only 17% reported to have had no difficulty accessing services they required after the death of their parents.

The nature of services that children had a difficulty in accessing included: basic necessities like food, health and education among other services. The children reported that the local shopkeepers were not willing to advance credit services to them even when they assured them they could pay for the items on a certain day. This meant unless they had ready cash, they could at times go without food. Despite the fact the education is now free in Kenya; some children sited lack of school uniform and other learning materials. At times when their needs necessitated that they ask for assistance from their neigbours both materially and financially to support their health and education requirements, many individuals were reluctant to so. They alleged that the children had no means of repaying them and therefore could not extend any credit service to them.

The children also reported that they had difficulties in acquiring births certificates. This is due to the fact that information about their birth dates and place was needed of which they did not have.

4.4.2. Exploitation

Diagram 10: Exploitation



When the children were asked if anyone had taken advantage of them, 90% reported having been taken advantage of while 10% were not. Both boys and girls reported that they either did work which they are not paid for and in addition, girls reported being sexually abused. They reported that some people did not pay for the services offered by the children fully since they claimed that they could not be paid like grown ups although the service rendered was the same. Girls sighted instances when men had approached them for sexual favors in exchange with food or money. One of the girls described how a shopkeeper almost raped her when she declined to sleep with him. He hauled insults at her claiming she had attempted to steal from him. She says this really made her miss the protection of her parents.

The children reported that their property had been grabbed by families and communities on demise of their parents. Some children cited to have been shown the grave of their parents as the only piece of land that they possessed and the rest was taken away.

4.4.3. Psychosocial problems

They narrated how they have never forgotten memories of their deceased parents. It was evident from that the majority of children suffer feelings of loneliness, desperation and depression following bereavement and stress associated with shouldering an adult role at a young age, low self-esteem, fear, and a sense of alienation. During the parents' or guardians' illness and after their death, the family is stigmatized and the children are often rejected or discriminated against. One of the parents who was bedridden at the time had this to say, "***hii ugonjwa imenifanya kama moto. Siwezi hata kujipikia. Inabidi watoto wangu watafute chakula na wanipikie. Nikiwangalia nasikia bibaya sana kwasababu siwezi hata nikawasaidia. Ili kitu inanisumbua ni kujua kwamba hata nikakufa kama leo hawa watoto hawana mtu yeyote wa familia mwenye anaweza kuwasaidia***". This sickness has made me like a child. I can't even cook for myself. My children have to look for food and cook. When I look at them, I feel very bad because I can't even help them. One thing that disturbs me most is knowing that even if I died like today, my children have no one to turn to.

Some children expressed fear about their lives without their parents and explaining that their future is almost hopeless. They were not sure they will be able to complete their education and be able to have a bright future.

They explained that these psychological and emotional problems like lack of love; discrimination and stigmatization made them feel worthless and always wished their parents were alive. Some tried to elaborate their experiences by saying that they do miss a lot of things due to their parent absence. They expressed feeling of grief and trauma following the death of their parents. For these children, loss of parent/s means loss of everything like love, hope, protection or security, care and support. One child described how they felt jealous when they saw other children being hugged by their parents. They said they missed their parents and the days they spent together.

4.4.4. Lack of protection and parental support

Some of the orphans interviewed in this study described how they faced problems that required parents' intervention but on the contrary they did not have anyone to protect them. They pointed out instances when some members of the community sometimes accused them wrongly. They said that even when they knew they had done the wrong they did not have a voice. They explained that members of the community were very fast to point fingers at them when a wrong had been done for example if something was stolen.

4.4.5. Stigma and discrimination

Because of social exclusion and stigma attached to HIV, most orphaned children are vulnerable to sexual exploitation and labour abuse. Due to stigma and discrimination from some members of the society, many orphaned children are afraid of seeking basic social services like health, education.

Some of the orphans interviewed in this study provided their reasons for the causes of stigmatization and discrimination as the negative attitudes and misconceptions surrounding HIV transmission. Most of these children are assumed to be HIV positive since their parents died of HIV related illnesses. Some orphans said that some neighbors do not allow their children to play with them while others reject them which is so painful to them. This treatment has left the children feeling rejected and worthless. They said that to avoid this treatment, they keep to themselves and do not mingle with other children freely. Andrew (not his real name) told me in Kiswahili, "***wazazi wa watoi wengine wanatufukuza wakituona na watoto wao so tunajikalisha.***"(When parents see us with their children they chase us away and so we choose to keep to ourselves).

4.4.6. Disinheritance

Children who are solely responsible for their siblings struggle not only to support the household, but also to keep their homes. Property grabbing is a practice where relatives of the deceased come and claim the land and other property, is reportedly a serious problem for widows and child-headed households in Kenya. Traditional law in many rural areas dictates that women and children cannot inherit property. (Makame et al,

2002.). The study found that there were cases of relatives who chased away the orphans after the death of their parents and took over whatever property that had been left for them. This practice of property grabbing heightens the strain on extended families and increases the number of street children. (Geballe & Gruendel, 1998.). Some of the children described how they had been thrown out by their relatives and this has made their relation very poor. They confessed feeling very frustrated about this and not even willing to approach these relatives even when they were faced with an issue.

On paper, Kenyan inheritance law provides children with important protections when both parents die without leaving a will, their property is to be divided equally among their children, whether male or female. Yet, in reality, many children in Kenya do not inherit the property they are entitled to from their deceased parents, such as a house or apartment, land, or movable property. Unfortunately this has not been enforced or adhered to.

Peter (not his real name) a twelve year old boy said, "***When my father died, we went to the village for his burial and after the ceremony, my uncle pointed at my fathers grave and said that it was the only piece of property we owned in the village.***"

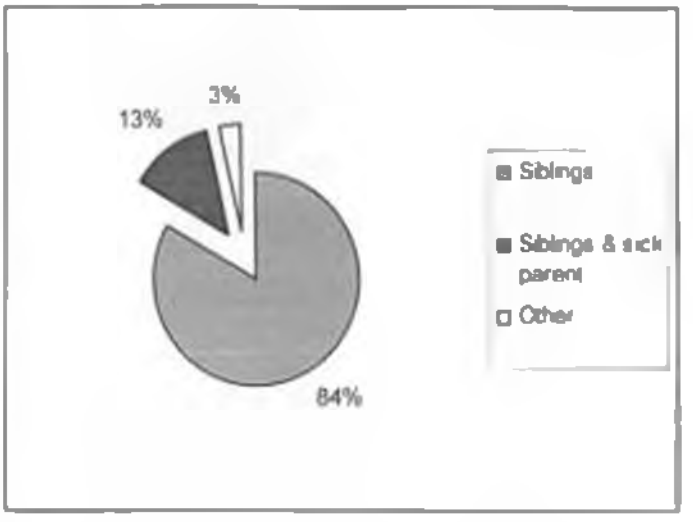
4.4.7. Poor living conditions

Through observation, the researcher found the living condition of these children very poor. It was evident that they were having severe problems of clothing, food, and shelter. Some of these children looked very malnourished and looked stunted. Most wore tattered clothes and some of their houses were in deplorable condition.

4.5. Channels used for survival

4.5.1. Existence of family/other support

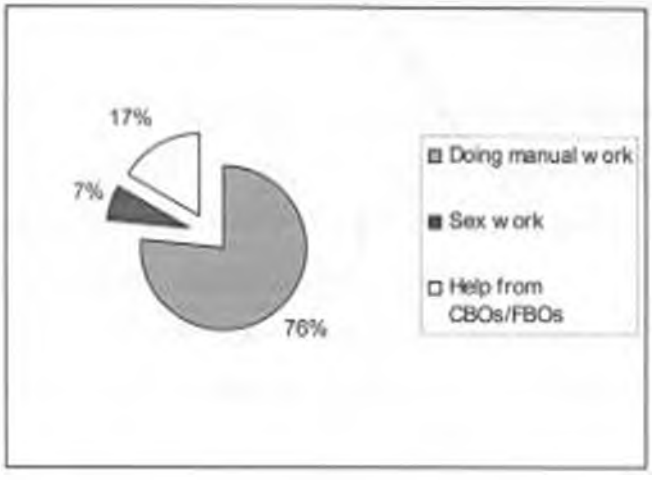
Diagram 11: Who orphans live with



The study revealed that 42 (84%) of the children interviewed lived with fellow siblings, 7(13%) with a sick parent and 1(3%) with other persons whom they said were relatives and family friends. In view of this, the key informants reported that the number of child headed households in the community is high that many people including relatives/friends and even children institutions are outstretched to absorb more orphans and vulnerable children. Thus a small percentage (3%) of orphans was supported by relatives and friends. Therefore most orphans live alone and support themselves. This also implies that the extended family system has collapsed and primary relations are no longer important contrary to traditional African expectations that allowed care and support to be extended to these children.

4.5.2. Acquisition of food and other basic needs

Diagram 12: Acquisition of food and other basic needs



The study findings indicate that 38 (76%) of children in child headed acquire food and other basic needs by doing manual work in local homesteads, 9(17%) were assisted by CBOs and FBOs with food and clothing and 3 (7%) engaged in commercial sex work. However, none of the child indicated to receive material support from relatives.

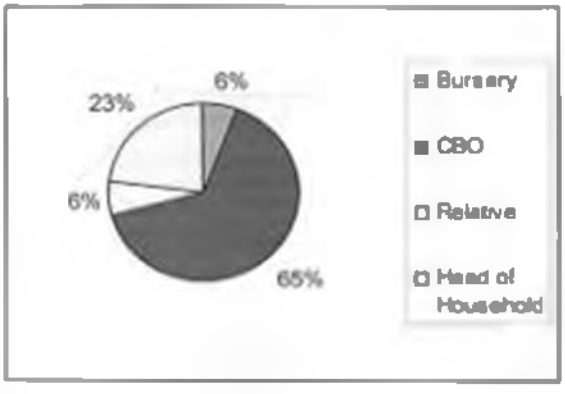
The work the children did include: washing clothes for neighbors, baby sitting, washing dishes in food kiosks, splitting firewood, and hawking groundnuts cigarettes and selling rotary tickets. In this study, the author found out that most of these Orphans suffer from low quantity of food and often others survive on rotten and thrown away food stuffs which they scavenge from market places and waste from local food kiosks. The study also found that, in most cases, they engage in hazardous labour in exchange for food or prostitution for food. The children expressed their dissatisfaction on the amount they get as payment for their work. The children said that in most cases they earned between Ksh 30 - 50 despite doing the work equivalent to that of an adult. The employers claimed they were children so they could not earn as adults. This reveals utmost exploitation of children and child labour which is a form of child abuse which is in contravention of then the children's Act 2000 and the UN Chapter on the rights of child and the African Charter on the Rights and welfare of the child.

With limited or no education, external support and no means to generate income to provide for their siblings and a sense of desperation, a number of orphan girls end up as prostitutes or get married at a very early age, often to much older men.

The children (girls) who engaged in commercial sex justified it as a way of making their ends meet and for the siblings they supported. During the interview one of the girls responded in Kiswahili: "***unajua nilazima tukule na tuvae kama watoto wengine. Kwa hivyo inatulazimisha kuwa wanaroadi***". (You know we must eat and dress like other children. So we are forced to do sex work). The key informant confirmed that the children who engaged in commercial sex work were girls and at adolescent stage.

4.5.3. Source of school support

Diagram 13: Source of school fees



Among the interviewed children who were in school, 32(65%) reported that they got education support from community based organizations,12(23%) from households' heads who were fellow children. Only 3(6%) of the children got bursary funds for their education support. Another 3(6%) of those received their support from relatives.

In view of support systems in place, most children in CHH face a higher risk of not going to school or leaving school early, since the structures in place for support are not sustainable. The community based organizations mainly depend on donor support that is time bound based on their programs in place in specific regions, therefore when the funding is terminated, the education support for theses children also ends. The children

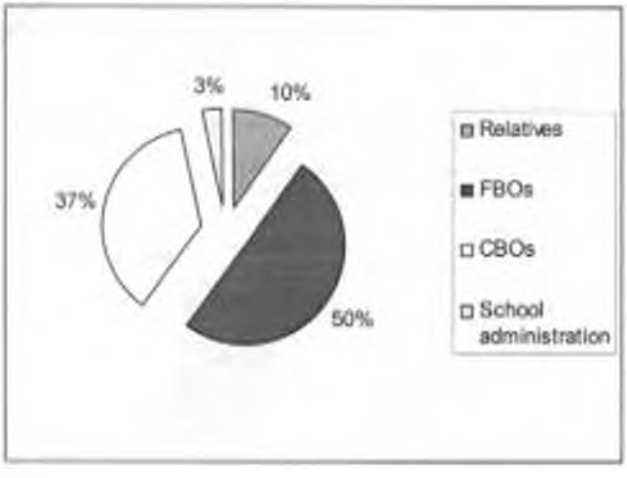
heading the households are unlikely to complete their education since other basic needs are given first priority which they are obligated to provide to the younger siblings The girls were reported to be even more vulnerable since they left school earlier to take care of their siblings either through getting employment or engaging in sex for commercial gains.

The affected children find it hard to attend school because of lack of money for buying reading materials even if they do, the majority do not attend school regularly because they feel tired, lack enough food to sustain them during school days or because of frequently occurring sickness of their parents. Most of them have to work late into the evening to make ends meet by selling cigarettes, roasted grain, and lottery tickets.

4.6. Sources of emotional and material support by child headed households

4.6.1. Source of psychosocial support

Diagram 14: Psychosocial support



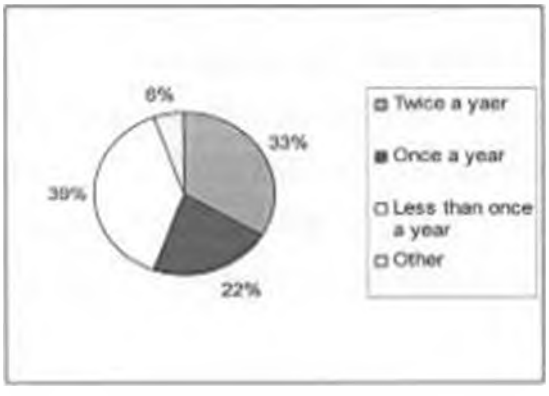
The research found out that the sources of psychosocial support for the children were: FBO 25 (50%), the CBOs 19 (37%), relatives 5 (10%) and school administration that supported 1(3%) of the children. The FBOs that supported the children were mainly the

church in the community where the parents of the children and the children themselves congregated for prayers during the worship days The form of psychosocial support extended to them was mainly spending moment of sharing and prayers by the religious leaders during the worship days for the children who attended the church services.

The CBOs which were mainly women groups, youth groups and charitable organizations offered counseling services regarding the worries the children had about their future lives among other issues. These were mainly the CBOs which emerged in response to the plight of orphans in the community. The school administration and especially the class teachers in the schools where the children were pursuing their education identified children in distress and offered the necessary guidance, counseling and referral where necessary. This included conducting follow up about their schooling needs and relationship with other pupils/students in the school. The teachers also dealt with the issue of stigma due to the fact that most of these children's parents died from HIV and AIDS related illnesses. There were those who received support from relatives mainly from their mothers' lineage in form of consolation during mourning period of their parent s demise and during the occasional visits by these relatives.

4.6.2. Support by relatives

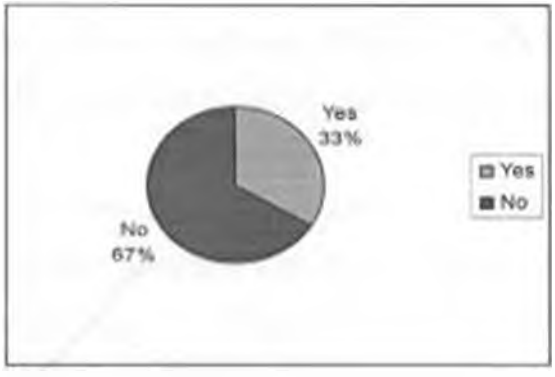
Diagram 15: Frequency of visits



All the children interviewed reported that they had relatives. However, the frequency of visitation by their relatives declined after the demise of their parents. When asked how often they were visited by their relatives, 19(39%) said less than once a year, 17(33%)

said twice per year, and 11(22%) once per year. They further clarified that the relatives who visited them were maternal and very few were visited by paternal relatives. This the children said even when they have problems they rarely approached their paternal relatives. The children explained that even when their parents were living, the maternal relatives were closer to them than the paternal ones. So after the death of the parents the maternal relatives still regards those children as theirs. The matrilocal status of children is similar to findings of Oscar Lewis (1996) in 'The culture of poverty' where the poor families have a heavily matrilocal orientation.

Diagram 16: Support by relatives



Of the children interviewed, 33(67%) reported that they did not receive any form support of from relatives and 17(33%) reported receiving support. The form of support that was mentioned by the children is food stuff, school fees and clothes. The children who reported receiving food support worked for their relatives as baby sitters, house girls or help in doing other manual jobs in return for food. Those who received clothes were given the ones that had outgrown their relatives' children. From their responses, it is clear that what children called support is not actually support but a form of payment for the services they rendered to their relatives.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 Summary of Findings

The study found that HIV and AIDS coupled with the breakdown or weakening of the extended family network has lead to the emergence of child headed households. Children in these households are facing challenges such as lack of parent's love and affection, protection and care, lack of basic necessities like food shelter and health care, social exclusion and stigmatization, disinheritance, exploitation abuse. Most the children interviewed confessed suffering stress resulting from assuming adult roles and responsibilities of caring with no resources or minimal resources for many needs.

The study found out that these children have had to compromise on their education, combine work and school or engage in child labour and other hazardous work to make ends meet. It is evident that there is gross abuse of these children's rights. Their right to protection, education healthcare and inheritance has been compromised.

5.2 Conclusion

Child headed households (CHHs) has been identified as an emerging phenomenon in Kibera slum. The study revealed that the major cause of orphan hood leading to emergence of these CHHs in Kibera is HIV/AIDS. The overwhelming stress on the conventional orphan support systems has forced the acceptance of CHHs as an alternative form of orphan care. This has attracted support from communities, women self-help groups (WSHGs), CBOs, Churches and NGOs as opposed to the extended family network that is expected to take up parenting roles to the less fortunate children.

Children in these households have therefore developed unique resilience when their lives are changed radically due to the demise of their parents. They have developed various

coping mechanisms including: taking up of new roles, acting as household heads, making household decisions even when parents are still living, and supporting their siblings, at times suffering the agony of nursing their ailing parents. It also emerged that boys are heading the home as the girls move out to seek means of sustaining their siblings by offering domestic services as house helps; by extension girls have also indulged into commercial sex work in order to fulfill the same.

Children in CHH face numerous challenges including not being able to access education, health care, and food. Stigma and social isolation are also very common. These children are facing other forms of exploitation such as domestic labor, commercial sex and being disinherited by relatives upon demise of their parents.

The findings in this study also reveal that when the parent's dies it leads to income loss in the household/family, erosion of the social capital, lack of support mechanism and the reduction in quality of life of the orphans. This generation of children is going to grow up without socialization, emotional and economic support of their parents or their guardians.

In view of the above findings, the study acknowledges that the plight of children in CHH is rife in the community and therefore need to advocate for redress strategies that will enable these children live fulfilled live. It is therefore important to realize that: "***Children of the world are innocent, vulnerable and dependent. They are also curious, active and full of hope. Their time should be one of joy and peace, of playing, learning and growing. Their future should be shaped in harmony and co-operation. Their lives should mature, as they broaden their perspectives and gain new experiences***". (UN, 1990).

5.3 Recommendations

1. Children in child headed households need support mechanisms such as visits from community volunteers, modest levels of material support, capacity building in various aspects which include; skills about growing-up, including issues relating to sex, drugs and alcohol, household management, about laws and human rights,

conflict management in families, how to record family history and memories and skills in caring for sick people.

2. Interventions targeting Children in CHH should not destroy vital coping strategies and they should promote sustainable solutions by CHHs so as to avoid dependency on these organizations which may consequently jeopardize chances of survival in the event of the absence of such supporting agencies.

3. Since the big percentage of orphans in CHHs is adolescents, the specific needs of this category need to be adequately addressed. This group is largely ignored by virtue of their developmental stage that lies between adulthood and childhood. Most girls at their teenage are exploited sexually through early marriages; commercial sex and thus continuous sex education need to be emphasized to enable these girls to assert their sexual rights among other issues that make them vulnerable.

5.4 Suggestions of Areas for further research

1. More detailed scientific studies also need to be conducted to ascertain the impact of the living conditions that CHHs live in (without the supervision of parents/adults) on their growth and development processes of the orphans.

2. There is need for research on possible surrogate roles that NGOs, the Church and other players can undertake to compensate for absence of parents/adults in CHHs.

3. There is need to draw a comparison between the quality of life of orphans under other orphan care systems (especially in foster homes) with orphans in CHHs, would also enrich findings.

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APPENDICES

Appendix 1: Photographs

A section of Kibera Slums

Children playing outside their house in Kibera

A child headed household- at the background is the head of the household

Child in a child headed household taking care of her younger sibling

Appendix 2: Data collection tools

Name----------,----------
Village----------
Age .....
11-15-------1
16-18--------2
Are you head of the household
Yes----------1
No ----------2
Sex
Male 1
Female.....2
How many people live in this household?

2-5----------1
5 and above--------2

Status of parent
Sick.....1
Dead.....2
Separated.....3
Other(Specify).....4

Do you attend school ?

Yes----------1
No----------2
If yes, what level?
Primary.....1

Secondary.....2
Tertially----------3

If no why-

What is the highest level of education have attained

Primary.....1
Secondary.....2
Tertiary.....3

9 Do your other siblings attend school

Yes.....1

No--------2

If no why

10. If yes, who pays your fees and other school requirements?

Bursary----------1

FBO----------2

CBO----------3

Relative----------4

Head of Household----------5

11. Do you have parents?

Yes.....1

No.....2

If yes

Mother alone----------1

Father alone----------2

Sick mother.....4

Sick father.....5

None.....6

Other specify----------7

If no parents, what happened to your parents? Explain

12 Who else do you live with?.....

Siblings ----------1

Sibling & sick parent (s)-----2

Other----------3

If living with siblings alone,

13. Ask Since when ----------

Less than 1 year----------1

More than 1 year----------2

14 . Do you have relatives?

Yes 1

No.....2

If yes where do they live?

Why don't you live with them? .....

15. Do they visit you?

Yes.....1

No.....2

16. If yes how often?

Every month----------1

Twice a year----------2

Once a year----------3

Less than once a year-----4

17. When did they visit you last?

A month ago----------1

Six months ago----------2

A year a go----------3

Can't remember----------4

18. Do they give any kind of support ?

Yes----------1

No----------2

19. If yes, what form of support?

Clothes----------1

School fees and other materials----------2

Food----------3

Other----------4

If no why (explain)

Cause of death for parent or guardian

20. What was the cause of your parents' death?

Got sick----------1

Accident----------2

Don't Know----------3

21. If got sick then died, ask;-

What was he/she ailing from?(Describe)

HIV.....1

Other 2

Don't know-----3

Challenges faced by children child headed household

22. How the HIV/AIDS stigma does affect you and your siblings

23. Tell me how your life has changed since you lost your parents'guardian and how do you feel about it as an orphan

24. Please would you tell me how you survive manage in your daily living? Do you work or have you been working to support your siblings?

Channels used by children in child headed households for survival

25. How is the burden of caring your siblings and what are your coping strategies?

26. Tell me more about the challenges/problems you encounter in your daily life as an orphan especially in this Kibera slums?

27. How do you get food and other basic needs?

From doing menial jobs.....1

Sex work.....2

Begging from street.....3

Help from a relative.....4

Help from an FBO/CBO.....5

Provincial administration.....6

Other (Specify)

28. What work do your other siblings do to supplement your household needs?

29. How do your school fees and that of your siblings

From doing menial jobs.....1

Sex work.....2

Begging from street.....3

Help from a relative.....4

Help from an FBO/CBO.....5

School bursary……6

Provincial administration……..7

Other specify ……8

30. Where and how do you obtain learning materials like books

From doing menial jobs……1

Sex work……2

Begging from street……3

Help from a relative……4

Help from an FBO/CBO……5

School bursary……6

Provincial administration……..7

Other specify

31. Who usually assists you and in what ways

Form of support

Source of Support	Form of support

32. Whom do you turn to when you are faced with difficulties?

A relative……..1

Faith Based Organisation (FBO)……..2

Community Based Organisation (CBO)……3

School administration

Provincial administration……4

Other (specify)……..5

33. How do you divide various roles in the household? Who does what

34. As the head of the household, what are your responsibilities

35. Has anyone taken advantage of your situation?

Yes.........................1

No...........................2

If yes please explain