

London School of Economics and Political Science

Young Carers in Western Kenya
Collective struggles and coping strategies

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Declaration

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Morten Skovdal

Abstract

Whilst young caregiving in Africa is not a new phenomenon, research exploring the circumstances and well-being of young carers in Africa is recent and remains scarce. However, similar to studies about orphaned children, the literature on young carers has a tendency to represent them as vulnerable and passive victims at risk of poor mental health, downplaying structural problems such as poverty and undermining the active participation of children and community members in building resilience. This thesis contributes to an already emerging critical trend that seeks to counterbalance this narrow focus by exploring how children, through an interaction with their social environment, cope with difficult circumstances. In doing so, the thesis addresses conceptual gaps in the coping literature and develops, through an iterative process, a social psychology of coping. This thesis draws on a participatory action research project that involved 48 children and 16 adults from two rural communities in the Bondo district of Kenya. Data were collected through multiple methods (daily diaries, historical profiles, community mapping, photovoice, draw-and-write exercises, essay writing, individual interviews and group discussions) over a two-year period. The thesis provides an example of how research can be conducted through an intervention and in partnership with an NGO, illustrating how socio-ethical research can be conducted in a poor rural African setting. A thematic content analysis reveals the complex nature of caregiving and brings forward new empirical findings of young carers, including the continuity of their caregiving experiences, socio-cultural influences on caregiving as well as the kind of care they provide. The analysis also reveals some of the social and psychological coping strategies that the children draw upon. These include the children's ability to mobilise social support, engage in income-generating activities and build positive identities based around a social recognition of their responsibilities. As a result of these empirical accounts, the thesis concludes that the ability of a child to cope is shaped by 1) the on-going negotiation between individual and community which shapes a person's identity and access to local support networks and resources to tackle adversity, 2) the quality of the community they live in and its ability to share resources and 3) the children's different abilities to negotiate community support. This social psychological conceptualisation of coping opens up new levels of analysis for research and intervention, which take account of the need to identify and bolster the social psychological resources evident within communities that can facilitate or hinder support. To strengthen the resilience and coping of young carers and their communities, the thesis points towards the viability of community-based capital cash transfer programmes and gives detail to the social psychological resources that can facilitate or hinder the building of orphan competent communities.

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Acronyms

ACC	AIDS Competent Communities
AIDS	Acquired immunodeficiency syndrome
ART	Anti-retroviral Therapy
ARV	Anti-retrovirals
CBO	Community-based Organisation
CCCT	Community-based Capital Cash Transfer
CDF	Constituency Development Fund
CHW	Community Health Worker
DANIDA	Danish International Development Agency
DGSS	Department for Gender and Social Services, Kenya
DOH	Department of Health
DSDO	District Social Development Officer
ESRC	Economic and Social Research Council
FGD	Focus group discussion
GOK	Government of Kenya
HIV	Human immunodeficiency virus
IDI	In-depth Interview
NACC	National AIDS Control Council
NGO	Non-governmental Organisation
NPA	National Plans of Action
OVC	Orphaned and Vulnerable Children
OCC	Orphan Competent Communities
PAR	Participatory Action Research
PLA	Participatory Learning and Action
PLWHA	People/Person living with HIV/AIDS
PMC	Project management committee
RAAAP	Rapid Assessment Analyses and Action Planning
REPSSI	Regional Psychosocial Support Initiative for OVC and conflict
SDP	Social Development Professional
SSA	sub-Saharan Africa
UNAIDS	The joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

Overview of chapters

In the *Introduction* I situate the thesis within the AIDS and orphan literature, providing an overview of HIV/AIDS in sub-Saharan Africa (SSA) and issues related to the care and support of people living with HIV and AIDS (PLWHA). I also discuss the concept of orphanhood and present some of the definitions used in the orphan literature. In discussing ways to support young carers, I briefly introduce the different types of cash transfer initiatives, which are increasingly cited as promising social protection strategies to support Orphaned and Vulnerable Children (OVC). I explain my personal interest in the subject, including my conviction that a narrow focus on children's psychosocial problems undermines recognition of their active participation and ability to cope. I conclude the introduction by presenting the overarching objectives of this thesis.

Chapter one seeks to position the thesis within the existing and relevant literature to young carers. To do this, the chapter reviews sociological accounts of childhood in the context of international development and HIV/AIDS and examines the representations of OVC in Africa, including the growing focus on their psychosocial distress. The chapter then reviews the research about young carers in the UK and Africa, and highlights how Western understandings of childhood, representations of OVC, and young carers research in the UK have all influenced the existing young carers research, encouraging a narrow focus on their problems and vulnerabilities. This is often translated into a focus on their psychological problems. I challenge the emergence of psychopathological research on orphaned and caregiving children in Africa and discuss the dangers of such a trend. Based on my review of the literature I conclude this chapter by outlining seven research questions to challenge the trends and fill some gaps identified in the literature.

In order to provide an alternative way to explore and support the needs and vulnerabilities of young carers, *Chapter two* seeks to develop a theoretical framework that encourages a community-level focus on the analysis and action of young carers. In my attempt to promote a social psychological understanding of coping, I present the orientation (salutogenesis) and discipline (community health psychology) that guide me and situate the need for a social psychology of coping within the existing public health agenda. I then review the existing literature on resilience and coping and highlight the need to develop a community level understanding of coping. To situate the social psychology of coping within the context of orphaned and caregiving children, I review five social psychological resources (dimensions of an orphan competent community) that can facilitate or hinder the coping of orphaned and caregiving children. To make this theoretical framework actionable, I complete this chapter by discussing how these five social psychological resources can be strengthened if community members get involved in participatory learning and action techniques, and discuss the potential of community-based capital cash transfer approaches in facilitating these participatory processes and thus a social psychology of coping.

Chapter three presents the research design and study methodology. This chapter aims to provide a transparent account of how the data for this thesis were collected and analysed. It briefly outlines the multiple methods used and provides a step-by-step account of the analytical process that

brought forward six global themes representing key findings, each of which is discussed in the findings chapter. Chapter three also discusses the importance of doing research *with* children and some of the socio-ethical dilemmas of doing research with vulnerable children in a poor rural African community, and how some of these may be overcome by involving the children in an action research project.

The first findings chapter is *Chapter four*. This chapter presents a nuanced overview of the circumstances that characterise young carers (as described by the children and the adults) in my study. It gives an account of the local context and understandings that may contribute to their well-being or struggles. As very little research has been conducted on young carers to date, and none in Kenya, the chapter also presents a more descriptive account of their duties and responsibilities, who they care for and the socio-cultural path that leads them to young caregiving. This chapter concludes with a figure that situates young carers on a continuum within their ecological context, highlighting the nuanced and complex circumstances that contribute to their experiences.

Against the background presented in Chapter four, *Chapter five* outlines the social coping strategies that are evident at different ecological levels. This includes children actively navigating and negotiating support from schools, church groups, faith, community groups and members as well as their immediate and extended families. An additional strategy is for the children to actively engage in income generating activities such as farming or keeping animals. My account of the children's participation in community life emphasises their agency and competence and challenges any simplistic conceptualisation of young carers as passive victims.

Chapter six looks at children's psychological coping strategies. It presents some of the many positive meanings that the children were found to attach to their circumstances, supporting my reservations about a narrow focus on their psychological ill-health or problems. The chapter also explores some of the negative meanings that some children gave to their situations and discusses how their social environment may facilitate or hinder the positive meanings and experiences of young carers.

Having outlined the indigenous processes and the social psychological resources that impact on the children's psychosocial well-being in chapters four to six, *Chapter seven* presents data from an intervention (community-based capital cash transfers) that sought to strengthen these resources through participation. The chapter presents a detailed account of the partnership between a local NGO and the children in facilitating the project/process and alludes to some of the practical outcomes of the project, including knowledge, skills and access to income. However, in agreement with the theoretical framework presented in Chapter two, the social psychological resources (supportive social spaces, shaping of social identities, agency and awareness of local strengths) generated from the participatory process are of great significance and relevance in building the resilience of this group of children. This chapter concludes with a discussion of some of the many difficulties experienced by the children and the local NGO in implementing this programme.

The final and concluding *Chapter eight*, synthesises and discusses the empirical findings presented in the thesis, and explores how this research has advanced our understanding of the needs and circumstances of young carers, as well as their coping strategies and ways in which they can best be supported. Reflecting on these findings, the chapter returns to the theoretical framework and provides a social psychological understanding of coping. To provide a framework for the analysis and action of communities facilitating the coping of its children within, the social psychological resources, or building blocks of an orphan competent community, are then revisited and fine-tuned in accordance to the findings presented. The chapter concludes with a discussion of the implications for policy and practice, which include the need to approach children as active and competent social beings whose psychosocial well-being is influenced by their social interaction and opportunities to build positive identities, mobilise social support and generate income. To increase those opportunities and improve their psychosocial well-being, the social psychological resources discussed in this thesis must therefore be promoted and facilitated through participatory and community-based programmes (such as community-based capital cash transfers).

Part A - Introduction and background

HIV/AIDS in Africa

With an estimated 22 million adults and children living with HIV/AIDS, sub-Saharan Africa (SSA) is the region of the world with the greatest concentration of HIV cases, making up almost 67% of all HIV cases worldwide (UNAIDS, 2008). With 2 million AIDS deaths in 2007 alone, SSA accounted for more than 75% of all global AIDS deaths (UNAIDS, 2008). Despite the fact HIV prevalence rates are slowly stabilising, with certain countries reporting a decline, the region still saw an estimated 2.7 million new HIV infections in 2007 (ibid.).

Although antiretroviral therapy (ART) is increasingly available, only 1 million of the 4.6 million people in need of ART in SSA are receiving it (UNAIDS/WHO, 2006). However, a number of obstacles, including poor infrastructure and opportunity costs (Unge et al., 2008) as well as changes in interpersonal relationships (Murray et al., 2009) have meant that many people continue to live without life-improving medicines or are simply unable to adequately adhere to strict treatment plans (Dahab et al., 2008; Posse, Meheus, van Asten, van der Ven, & Baltussen, 2008). A study in Tanzania revealed that fear of stigma and discrimination, additional costs of transportation and supplementary food and negative associations with hospital staff have deterred HIV infected people from following up on referrals for ART (Mshana et al., 2006). Recent findings from Malawi suggest that non-adherence can result in relapses and drug resistance and general poor compliance to ART can result in increased mortality (Chen et al., 2008).

These difficulties highlight the importance of understanding the implications for long-term care of people living with HIV/AIDS. Primary caregivers continue to play a crucial role in facilitating the adherence of treatment plans and the provision of economic, nursing and moral support (Chimwaza & Watkins, 2004; Kipp, Tindyebwa, Rubaale, Karamagi, & Bajenja, 2007). Family caregiving is often perceived to be a burden on the caregivers and they are increasingly reported to be at risk of poor health and psychosocial distress (Kipp, Tindyebwa, Karamagi, & Rubaale, 2007; Shifren, 2009). The majority of research on informal caregivers of people living with HIV/AIDS is focused on women (Kipp, Tindyebwa, Rubaale et al., 2007; Nkosi, Kipp, Laing, & Mill, 2006), however, growing attention is being given to children who provide care and in the process witness the slow disintegration of a parent without adequate access to analgesic drugs and palliative care (Robson, Ansell, Huber, Gould, & van Blerk, 2006).

The phenomenon of children's caregiving of adults affected by AIDS has alarmed many academics, policy makers and mental health professionals. Like their adult counterparts, children providing care and undertaking domestic responsibilities have recently been associated with poor mental health (Bauman et al., 2006; Bauman, Johnson Silver, Berman, & Gamble, 2009; BBC News, 2009;

Cluver, undated; Donald & Clacherty, 2005; Martin, 2006; Shifren, 2009; Zhang et al., 2009). This study will argue that concurrent to an emphasis on the negative impacts of caregiving should be a focus on the children's active participation in coping with adversity. To date, nobody has looked specifically at the active role of young carers in coping with difficult circumstances. A good starting point to develop an understanding of why that is, is to look more broadly at the literature which surrounds OVC.

Orphaned and vulnerable children

Mirroring the high HIV/AIDS prevalence rates, *The State of the World's Children 2009* report by UNICEF states that SSA is the region of the world with the greatest proportion of orphans, totalling 47.5 million (UNICEF, 2008b). With 2.5 million orphaned children (approximately 15% of all children in the country), Kenya is facing the challenge of providing adequate care and support for this growing number of orphans (ibid.). Whilst these statistics do not give any indication of the individual human suffering and the battles that families and communities fight to cope, they intend to portray the scale and trends of the phenomena. There are no official and reliable statistics on the prevalence of young caregiving in Africa, but Robson et al. (2006) refer to a study from the 1990s, which suggests that about 4% of children aged between 7 and 14 years in Tanzania have engaged in caring for sick relatives in the last week. Evans and Becker (2009) argue that the AIDS epidemic has progressed significantly since this early study and that a higher proportion of children are now likely to be involved in caregiving. Although HIV/AIDS is a likely cause for young caregiving, there are other circumstances that lead to children providing care (e.g. disability and other tropical diseases).

Nevertheless, before accepting the statistics presented above, it is important to recognise that a number of variables can influence the quality of data, including linguistic variances, local perceptions and not least, varying definitions. As a result, the reported prevalence of orphanhood differs across sources. Bennel (2005) draws attention to discrepancies in the data available and highlights that *Children on the Brink*¹ typically has estimates 30-50% higher than national Demographic Health Survey (DHS) figures. Bennel (2005), for example, points out the DHS figure for the number of double orphans (under age 15) in Kenya is 9.4%, whilst the *Children on the Brink* report estimate this figure to be 12.4%, giving a 32% divergence between *Children on the Brink* and DHS. Care must therefore be taken when reading and interpreting the statistics provided throughout this thesis. Table 1 illustrates the estimated number of orphaned children in Kenya according to the National AIDS Control Council of Kenya (NACC, 2006).

¹ *Children on the Brink* is a joint UNICEF, UNAIDS and USAID publication, which is generally accepted to provide the international standard definitions and estimates of children affected by AIDS (Bennel, 2005; Smart, 2003)

Number of orphaned children by type in Kenya, 2005	
Maternal orphans	1,414,000
Orphan due to AIDS	849,000
Non-AIDS	565,000
Paternal orphans	1,337,000
Orphan due to AIDS	482,000
Non-AIDS	855,000
Double orphans	439,000
Orphan due to AIDS	343,000
Non-AIDS	96,000
Total orphans	2,311,000
Total orphans due to AIDS	1,044,000

Table 1: Orphan numbers in Kenya (NACC, 2006)

One of the reasons behind differences in estimates is that the definition of an orphan differs from country to country and changes over time. The two main variables include age (children up to the age of 15 or 18) and parental loss (mother, father or both) (Smart, 2003). Table 2 presents some contemporary definitions used nationally and internationally. Andrews et al. (2006) note that the definitions used by international, as well as local organisations do not take into account local interpretation and realities. Bray (2003, quoted in Andrews et al., 2006) for example, has observed that the word orphan in many African countries refers to a child without care as opposed to without parents. Although I would reiterate the importance of drawing on local and contextual understandings of orphanhood, I do realise that this may further confuse and complicate the use and interpretation of studies that look at the impact of orphanhood and undermine international responses (Sherr et al., 2008).

Definitions of orphaned children from Selected African Countries (Smart, 2003)		Internationally recognised definitions (UNICEF, UNAIDS & USAID, 2004)	
Kenya	A child under the age of 18 who has lost at least one parent.	Orphan	A child under the age of 18 who has lost one or both parents.
Namibia	A child under the age of 18 who has lost a mother, a father, or both – or a primary caregiver – due to death, or a child who is in need of care.	Maternal orphan	A child under the age of 18 whose mother, and perhaps father, has died (includes double orphans).
Botswana	A child below 18 years who has lost one (single parents) or two (married couples) biological or adoptive parents.	Paternal orphan	A child under the age of 18 whose father, and perhaps mother, have died (includes double orphans)
Uganda	A child below the age of 18 years who has lost one or both parents.	Double orphan	A child under the age of 18 whose mother and father have died.
Rwanda	A child who has lost one or both parents.	New orphan	A child under the age of 18 who has lost one or both parents in the last year.
Ethiopia	A child less than 18 years of age who has lost both parents, regardless of how they died.	'Vulnerable' child / social orphan	A child whose survival, well-being, or development is threatened by HIV/AIDS (e.g. if providing care for ailing parents)

Table 2: Orphan definitions

Nevertheless, looking at Table 2, a vulnerable child in the HIV literature refers to a child whose survival, well-being, or development is threatened by HIV/AIDS. However, the definition of vulnerable children is fluid and raises a number of questions. What is vulnerability? According to whom is the child vulnerable? Under what circumstances is the child vulnerable? What role do researchers and NGOs play in making African children vulnerable? I will elaborate on these definitions and understandings later in the thesis, but I would like to flag a related concern that I share with Meintjes and Giese (2006). Whilst I only have anecdotal observations, Meintjes and Giese have observed in South Africa how Western understandings of orphanhood have changed the terrain in which orphaned children access and negotiate support from their social environment. They have found that children decide to 'become orphans' in order to qualify for assistance. I believe that such observations raise important questions about how support for children in difficult circumstances is best articulated and implemented. To elaborate on this, I will seek to highlight how current trends of research into the problems and psychological distress of OVC, and increasingly young carers, could potentially undermine local coping strategies. In light of this concern, one of the aims of this thesis is to explore the existing coping strategies of young carers and encourage a community-level focus to analyse and promote the psychosocial well-being of young carers and OVC more generally.

Orphanhood and care

With AIDS sweeping across SSA and the numbers of OVC growing, it is increasingly believed that traditional support mechanisms and fostering arrangements are overwhelmed (Foster, 2000; Nyambedha, Wandibba, & Aagaard-Hansen, 2003a, 2003b). In fact, the *2008 State of the World's Children* by UNICEF (2007:42) cautions that,

“Children can no longer rely on the support of the traditional extended family system, which provided care and support for the aged, orphans and any vulnerable and disadvantaged family member. This coping mechanism has been overstretched by poverty and the sheer numbers of children to be cared for, given the fact that AIDS affects the most productive family members in the prime of their productive and reproductive lives. As a result, children have sometimes gone into homes that are already overstretched and where they are really not welcome” (words of Elezabeth N. Mataka, United Nations Special Envoy of the Secretary-General for HIV/AIDS in Africa)

Numerous rapid assessment analyses and action planning (RAAAP) reports and national plans of action (NPA) have been produced by national governments in the hope of providing the astounding number of OVC with adequate care and support. A review by Sabates-Wheeler and Pelham (2006) of NPAs and RAAAPs from 14 countries in SSA highlighted two paradoxical assumptions that form the foundation for the NPAs. On the one hand they argue that traditional social coping strategies are overwhelmed and at the point of collapse. On the other hand, the NPAs were found to suggest

that OVC are located in a social environment that have the potential and willingness to provide care and support (Sabates-Wheeler & Pelham, 2006).

Although there is a need to reconcile these seemingly contradictory assumptions, many of the multilateral funded child-focused social protection schemes currently being tested and implemented in SSA are a response to the former narrative (social support networks are overstretched), focusing on the welfare support of households (cf. Case, Hosegood, & Lund, 2005; Schubert, 2005; Schubert & Slater, 2006). This move is arguably a reaction to the progress made in South America where household- and stipend-based conditional cash transfers have been very successful in improving school attendance and child health (Fernald, Gertler, & Neufeld, 2008; Handa & Davis, 2006; Lagarde, Haines, & Palmer, 2007). In 2004 the Government of Kenya and UNICEF piloted a household- and stipend-based cash transfer programme, targeting the households of 500 OVC in three districts. In 2006/07 the programme involved four districts and targeted 2500 households. With further funds made available from the World Bank, the Government of Kenya is currently in the process of scaling up to include 37 districts and increase the number of households benefiting to 100,000 by 2012. Using a standard criteria to identify needy OVC, the programme disburses Ksh1,500 (approximately €15) per household per month with the aim of enhancing the households' capacities to meet their basic needs and further the well-being and educational attainment of OVC (Pearson & Alviar, 2008).

Whilst I agree that such initiatives have an important role to play in the social protection of OVC and their educational attainment (Case et al., 2005; Kakwani, Soares, & Son, 2006), it has been noted that such household-based cash transfer initiatives can undermine traditional and community-based coping strategies (Jones, Vargas, & Villar, 2008; Thurman et al., 2008). This suggests that stipend and household-based cash transfers could benefit from including community-based activities that can facilitate the identification and selection of vulnerable children and possibly the distribution of cash. Such a cash transfer initiative is currently being tested in Tanzania (Evans, 2008). In my effort to promote and advance such community-based activities and responses to OVC, I want to explore the potential of a complementary cash transfer model to the more traditional and household-based cash transfer model. In doing this, I seek to support one group of OVC, namely those children providing care for relatives. This model acknowledges both the constraints faced by communities in offering children support amidst disease and poverty, as well as the potential of communities to provide support. This model seeks to provide the community with the financial and social psychological resources to strengthen and support existing community-based responses. I have conceptualised this model as community-based capital cash transfer (CCCT) (Skovdal, Mwasiaji, Morrison, & Tomkins, 2008).

My conceptualisation of CCCT was developed through my previous involvement with the Danish International Development Agency (DANIDA) funded Community Capacity Support Programme in 13 districts across Kenya. The programme sought to facilitate a number of participatory processes that aimed to empower communities and provide them with the social psychological resources that

enable them to build on local responses and effectively strengthen the well-being of those living within these communities.

Administered by the Department of Gender and Social Services (DGSS) and with support from DANIDA, the process of implementing CCCT in each community was similar to that of the participatory action and learning cycle outlined by Rifkin and Pridmore (2001). The first step of the project cycle involved the sensitisation of community members (leaders, teachers and parents/guardians) to orphan issues and child rights and the election of a village development committees (VDC) and project management committees (PMC). This was followed by a rapid appraisal of orphaned and other children in difficult circumstances by the communities who subsequently wrote up action plans that could solve some of the obstacles faced by the communities in providing care and support to OVC. PMC members, in consultation with community members, identified between 65-100 orphaned children as being 'the most needy' and who were to benefit from the community initiative fund. No rigid criteria on orphan selection were imposed. When the action plans were approved (some were only approved following advice and suggestions by the district social development officer), community bank accounts were set up and a capital cash transfer of €4,000 allowed the PMC, with support from the village development committees and advice from the DGSS, to implement the activities they had prioritised. I will describe this project cycle and how I intend to adapt it to my action research project in greater detail in chapter two.

As the above paragraph indicates, I use the term community loosely. However, when speaking of community, I acknowledge that there will be varying factors shaping community membership and refer to a community as both a resource for empowerment and as a means of marginalisation and social exclusion. For practical reasons, social development interventions, like the one above, tend to focus on geographical areas as the area of a collective activity. Similarly, in this thesis I will explore the circumstances of a community of children (young carers) within their geographical community. Because the children live and study there, they interact with a variety of stakeholders in an inter-dependent system, including family, neighbours, friends, teachers, community and faith-based group members and NGO workers, all of whom will be considered in this thesis.

As orphanhood is strongly correlated with AIDS in the place of study (Bondo district of Kenya) (Muthengi, 2005), it is only natural to locate this study within the AIDS literature. However, as the above background has briefly alluded to, locating this study within the African AIDS literature is not unproblematic. It has been argued that the literature is underpinned by Western representations of 'African culture', which direct international AIDS research policy positions and construct Africa as a client in need of expert advice (Patton, 1989, 1999). Whilst this thesis, somewhat paradoxically, acknowledges the difficulties faced by young carers and recognises the need to draw attention and support to this group of children, it also challenges the view of young carers as necessarily passive and vulnerable victims in need to external support – all with the aim of bringing forward a more complex understanding of their lifeworlds. In my effort to balance this seeming paradox, I hope to argue in this thesis that support should be facilitated, based on local responses and in dialogue with the communities involved, and not be imposed by outside 'experts'. Nevertheless, as a doctoral

student in London doing policy-oriented research in Kenya, I am aware that I too fall under the category of expatriates providing 'expert' advice in an African setting. However, I hope that my research provides a critical perspective on the assumptions made by many of my peers, policy makers and 'professionals' who are providing expert advice in African settings.

Cultural context

It is evident that the HIV/AIDS epidemic has affected many families in SSA. However, to fully understand the agency and coping strategies of children and households affected by AIDS, an account of the cultural context, its continuity and change, is necessary. This section therefore introduces some of the anthropological literature which discusses some of the African cultural practices, representations, systems and shared attitudes that may have an impact on the vulnerability and coping capabilities of orphaned and caregiving children. As this study takes place in the Bondo district of Nyanza province, links will be made to cultural systems of the Luo ethnic group, the second largest ethnic group of people in Kenya. They occupy areas of South and Central Nyanza and came to Kenya as part of an extensive migration of Lwoo speaking people from Sudan (Potash, 1978).

One important African practice that helps orphaned children is that of child fostering (Madhavan, 2004). Children's movements have been described in relation to child fostering in a number of African communities (Goody, 1970; Nyambedha & Aagaard-Hansen, 2003). Historically, Africa has had to deal with high rates of maternal mortality, and according to Preble (1990), this may have contributed to the willingness of family and clan members to foster orphaned children. Additionally, children have traditionally been fostered by grandparents and other extended family members in order to share the costs and benefits of children or for the children to access certain religious or educational institutions (Caldwell & Caldwell, 1987; Lloyd & Desai, 1992). It is this continued willingness and norm of child fostering, often requiring children to migrate, that has ensured that the majority of AIDS-affected children are cared for and fostered by their extended family (Foster, 2002). However, the HIV and AIDS epidemic has increased the number of children requiring foster care and concerns have been raised about whether family and clan members can keep up with the growing number of orphans (Foster, 2000). In this debate Madhavan (2004) has highlighted a distinction between voluntary fostering and crisis-led fostering, which often characterises the situation of children orphaned by AIDS.

Nevertheless, reflecting on the pressures presenting extended family and clan members as a result of the HIV and AIDS epidemic, Ankrah (1993) discusses the continued role of clan and family members in taking care of orphaned children. She argues that AIDS-affected or infected children will not be without family or clan members, believing that the African clan system is fully committed to the economic and social support of orphaned children. She acknowledges changes and a re-organisation of the family and clan structures, but is optimistic that new arrangements – and a broadening understanding of social networks and clan membership – will succeed. In Bondo, amongst the Luo, such a re-organisation has been observed by Anthropologists Nyambedha and

Aagaard-Hansen (2007). The Luo maintain a patrilineal lineage system through which individual homesteads are distributed in lineage neighbourhoods (Potash, 1978; Southall, 1952) and they have explored the re-invention of *Duol*, a concept signifying unity and solidarity within a lineage under the authority of elders (Nyambedha & Aagaard-Hansen, 2007). The *Duol* would often refer to a house where only men and boys would be allowed to enter and where important matters of the community would be discussed (ibid.). Women had a similar house, called the *Siwindhi*, where traditional beer parties, collective meals and the socialisation of children would take place. More importantly, the *Siwindhi* would also host children – including orphans – and women unable to prepare meals, serving as a safety-net for the most vulnerable people in their lineage. Whilst *Duol* and *Siwindhi* are no longer practiced in the traditional sense, Nyambedha and Aagaard-Hansen (2007) have argued that a new form of *Duol* dominates the daily operations of Anglican and Catholic churches in Bondo as well as through the numerous community-based organisations that provide care and support for people affected by AIDS – including children. Unlike the traditional *Duol* system, the current system transcends kinship patterns and other traditional and gendered relations in Luo social life – responding to contemporary challenges and HIV and AIDS (Nyambedha & Aagaard-Hansen, 2007). So whilst traditionally orphaned Luo children would be cared for within their patrilineal lineage system, Nyambedha (2004) now believes that orphaned children can – thanks to church and donor assistance – choose when and for what purpose they should draw on family and clan ties and when to seek support beyond the extended kinship group. I hope this thesis will be able to add some light to this very optimistic assertion by Nyambedha.

As mentioned earlier, the Luo maintain a patrilineal lineage system and as the *Duol* and *Siwindhi* indicate, many of their cultural practices are gendered, favouring men. Patriarchy and respect for men (particularly elderly men) does characterise the Luo way of living (Southall, 1952). Although polygamy is on the decrease, most adolescents in Bondo have been raised to polygamous parents, socialised into a patriarchal system. In an anthropological study of marital stability amongst the Luo, Potash (1978) notes that domestic life takes place in patriarchal extended family homesteads with each wife occupying a separate house. As this study may indicate, such arrangements have the potential to provide orphaned children with support as their biological mother dies and they move in with their mother's co-wife.

However, according to Potash (1978) jealousy between co-wives is endemic and largely unavoidable and can have severe consequences for children as the wives act out their jealousy – often leading to the discrimination of the orphaned children. Furthermore, wife inheritance (*ter* in Luo, meaning re-marriage) is commonly practiced amongst the Luo in order to secure the continuity of the family (Potash, 1978; Southall, 1952). When a husband dies, his wife is expected to be inherited, particularly those women who are within the bracket of child bearing age, by her deceased husband's brother or cousin. If the late husband died of AIDS, and if the surviving wife is HIV positive the inheritor may get infected and subsequently pass on the virus to his other wives. Wife-inheritance does not always happen (particularly if the husband died of AIDS) and the cultural impurity of not being inherited can leave the widow and children further marginalised (Potash, 1978). Polygamy and wife inheritance are some of the practices in Luo culture that help with the

spread of HIV, leaving children vulnerable and at risk. Moreover, widows and their children brought into a new homestead may be implicated by the same jealousy that exists between co-wives, which can lead to the discrimination of her children.

Orphanhood, poverty and discrimination leaves many children vulnerable to violence and sexual abuse. Sexual abuse of children has been identified as a major problem in Kenya (Lalor, 2004). In fact, a study in Kenya on violence and sexual abuse highlighted that 59% of those interviewed stated that their first experience with abuse happened in childhood and adolescence (Johnston, 2002). According to Jewkes, Penn-Kekana et al. (2005), the very scale of child sexual abuse in sub-Saharan Africa suggests there are entrenched ideas and practices that, if not legitimating, provide some kind of a space for these activities to happen. The gendered and patriarchal system that dominates Luo culture may provide such a space. Also age hierarchies, compounded in culturally derived authorities, can under certain circumstances make children more vulnerable (Guma & Henda, 2004).

Luo culture is characterised by a clear gender and age hierarchy, which governs social relations and dictates certain practices (Potash, 1978; Southall, 1952). Jewkes, Penn-Kekaka et al (2005) have found that in African patriarchal communities, the high status of men leads to the vulnerability of children, particularly girls, whose ability to refuse sexual advances is reduced by the expectations in men that they should control women and children (as the wife-inheritance practice symbolise). According to Nyambedha (2007) these gendered practices and ideas, coupled with a context of poverty, HIV and AIDS has created conditions in Bondo where orphaned children and adolescents are exposed to situations that make them more vulnerable to exposure to HIV through sexual abuse or exploitation. Although there are cases of virgin girls being raped in the belief this will cure the perpetrator from HIV/AIDS, Jewkes (2004) argues that this is not a worthy explanation for the many cases of sexual abuse that many SSA countries are seeing. It has been observed in Kenya that the vulnerability of orphaned children, compounded in lack of parental protection, poverty and a dependence on others, has encouraged some orphaned children to seek out older partners (or sugar daddies) in order to replace a parental figure, or to access some much needed resources which their foster homes cannot provide (Longfield, Glick, Waithaka, & Berman, 2004).

What the above discussion has highlighted is some of the cultural ideas and traditional practices that either serve to support or take advantage of disenfranchised children. The African family and kinship system, as well as the lineage system of the Luo in Bondo, have traditionally been caring for orphaned children. Whilst these systems of support are reported to have transformed, incorporating a wider range of social relations, other cultural ideas (notions of gender, patriarchy) leave orphaned and caregiving children susceptible to sexual abuse. These cultural practices and spaces serve as useful background to my study of children's vulnerabilities and coping strategies. This thesis must therefore be read and understood against the cultural fabric outlined above. Acknowledging the importance of culture, this thesis dedicates a chapter (Chapter four) to explore the local context in which these children's lifeworlds are located.

Personal context

I first got involved with AIDS care and support work in 2004 when I served as the programme development director of an Irish NGO operating in Kenya. Through the facilitation and monitoring of home-based care projects, I paid a number of visits to the homes of people living with HIV/AIDS (PLWHA) in some of the most remote communities in Kenya. I was continually humbled and inspired by the extraordinary commitment and efforts of community members in their mission to support PLWHA. They provided the sick and dying with psychosocial support, treated opportunistic infections and ensured basic comforts through to their final hours through palliative care. At the forefront in this provision of care were the children of the sick. The children washed, fed and provided emotional support for their ailing parent(s) and often had to additionally fend for younger siblings or ageing grandparents.

As a privileged Westerner I was appalled by the conditions in which the children were witnessing their parent(s)' slow disintegration. One of my Western colleagues, perhaps naturally, immediately assumed that exposure to such conditions and traumatic events, as caring for someone who was terminally ill, in conditions of dire poverty, would be traumatising and would affect the mental health of these children. Whilst I was more concerned about the poverty levels faced by the children, I did make note of my colleague's concern regarding their psychological health and consciously made an effort to observe their psychosocial behaviour when doing home visits.

Contrary to my colleague's assumption, my own perception was that the children appeared to cope fairly well considering the often tragic circumstances. Many of them had plenty of friends, appeared mentally sound, went to school, and were supported and encouraged to do so by neighbours and other community members. This was the first experience that inspired me to question the assumption that children's caring experiences were in some way inherently linked to psychosocial distress.

Acknowledging the difficult circumstances in which the children lived, I began to look into the social science literature on 'young carers' and on the psychological effects of orphaned and caregiving children, in order to contribute to the development of well informed aid programmes. I found a mismatch between the situation I had observed in East Africa and the way in which orphaned and caregiving children were represented in the literature. My initial impression of the literature was that it viewed the orphaned and caregiving children as passive, innocent and incompetent victims, rather than active and competent agents who coped and showed resilience. As much of the literature looks at the psychosocial distress experienced by orphaned and caregiving children (e.g. Cluver & Gardner, 2007a; Cluver, Gardner, & Operario, 2007; Makame, Ani, & Grantham-McGregor, 2002). it could be argued there is a danger of generalising from the hardship experienced by some children to that of all orphaned and caregiving children. Furthermore, as I read the literature on young carers in the UK, I soon realised, somewhat to my surprise, that I myself had been what the literature refers to as a 'young carer'. My much-loved mother suffered from Lupus, a chronic autoimmune

disease that is fatal. The ailment resembles AIDS in many ways in that it flares as a result of an ineffective immune system and has no cure.

Whilst I never perceived and knew myself as a 'young carer', the practical and emotional support I willingly gave my mother until the age of 17, when she sadly passed away, would label me as a 'young carer', making me a welfare category in light of the literature. Since her death I have spent many moments thinking about how the circumstances of my mother's ailment and experiences of early bereavement have affected me, and I have been unable to identify any negative impact this experience had on my psychosocial well-being. Of course the circumstances of my mother occupied much of my mind and energy, but I never felt that they compromised my life as a classmate, friend, brother and competitive swimmer. On the contrary, I learned to multitask.

I feel I can safely say that many of my achievements and successes today are a result of my experiences as a supportive son, and in some way, early maturity, experiences I would not have been without. Thankfully, no one told me or my mother that what I was doing, by being supportive, would have a negative impact on my development and well-being. Had I been told this, I might have seen myself as a victim, someone who suffers from hardship, and possibly felt like one too. I believe this would have had a negative impact on my development. This revelation strengthened my conviction to contribute to the literature on young carers, by presenting a more nuanced understanding of their experiences as carers.

Acknowledging the resource-constrained circumstances of young carers in Africa, the starting point to this study is that this group of children are in need of attention. However, on the basis of my practical experience of working in this field, I strongly believe that the primary basis for such attention should be through a focus on building supportive social environments, and tailoring these to the existing coping strategies of young carers rather than focusing on their problems and psychological needs. If children are facing psychological difficulties it will often not be due to the individual child, but due to society and prevailing representations in their social environment. Additionally, considering the complexity of the issue, it seems unhelpful to locate the problem in the child. One of my aspirations is to explore this issue, in the interests of providing a rigorous research assessment of the accuracy of the prevailing tendency to assume that the children's circumstances inherently predispose them to psychosocial distress.

Study objectives

In the interests of challenging the tendency to focus on the needs and problems of young carers, I will use the emerging focus on their mental health as an example. I therefore conceptually align myself alongside the 'anti-trauma movement'. This school of thought questions the consequences of psychosocial research and interventions (Argenti-Pillen, 2003). Trauma is often referred to as an emotional state of discomfort and stress following extraordinary experiences that can lead to antisocial behaviour (McCann & Pearlman, 1990). Here I must emphasise that I am by no means seeking to deny that some young carers and orphaned children show the symptoms of post-

traumatic stress and require psychotherapeutic support. I aim to facilitate a re-thinking of the current development of psychosocial research into orphaned and caregiving children by providing a social psychological perspective to the debate. The hope is that this will facilitate new and innovative ways of approaching the psychosocial well-being of orphaned and caregiving children in Africa.

Central to this argument is the underlying aim of this study, to problematise any one-sided stereotype of young carers as passive and incompetent victims with detrimental experiences. I strongly feel that conceptualising young carers as victims does not do justice to the outstanding coping skills and resilience that their social environments often allow them to develop and draw upon. Whilst the children need our attention, we should see them and approach them as active participants capable of coping despite hardship and adverse circumstances. This is not to deny that many children and their communities need support, but rather to reframe the way in which this support is conceptualised and offered.

Against this background the over-arching objectives of my thesis are:

- To provide empirical evidence for a more nuanced and accurate understanding of young caregiving in an African context, acknowledging the agency and competence of many (not all) children with caring roles.
- To develop ways of understanding coping as a function of the child's capacity to participate in the life of the community in which s/he is located, and
- To generate insights into the social psychological resources and forms of participation that work best in enabling this particular group of children to deal with their adverse circumstances.

To gather data that would support or challenge my claims and help achieve the aims of this study, I adopted a qualitative research methodology. As I dislike the idea of doing research with people without it being of benefit to them, I drew on the values of participatory action research, gathering data in a way that was empowering for the child participants. In a further effort to support the children and to provide a context in which I could investigate their capacity for social agency, the project investigated the potential of CCCT as a viable strategy to strengthen the psychosocial well-being of young carers.

This required that I arranged an intervention that involved setting up youth clubs through which young carers gathered for sports and peer support building activities. The children conducted a needs assessment using photography and drawings and as a result of their reflections, drew up an action plan which would target some of their common needs and concerns. The youth were given cash (equal to £50 per child active in the club) to implement their action plan. The children were the key participants and decision makers throughout the project cycle. I believe the process, in a social and community context, improved their problem solving skills, provided the children with confidence, and strengthened their sense of self-efficacy and hope for the future, while at the same time catered for their immediate needs.

When working with the children at a grassroots level, I actively avoided using labelling jargon, such as young carers and OVC. According to my own experiences and that of UNICEF (2004a), such jargon can eventually become used at the community level to identify particular children, and consequently these children are no longer just children but belong to a stigmatised or victimological² category. I acknowledge the danger of using labels and jargon to describe children and would ideally like to distance myself from the labelling of children affected by AIDS. According to UNICEF (2004), terms such as 'AIDS orphan' may contribute to a categorisation and stigmatisation of children. Ideally, I should use the term 'children affected by HIV/AIDS', which refers to orphaned and other children made vulnerable by HIV/AIDS, or 'children in difficult circumstances'. Both are terms which include young carers. However, to stay within the current discourse I will use some of the more popularly used labels and jargon, including acronyms such as 'OVC' (for orphaned and vulnerable children) and the terms 'young carer' and 'young caregiver'. In using these terms I will appeal to the research community on young caregivers. However, I do this with caution and awareness of the potential consequences.

As with all research, my personal background had an impact on how I approached this study. All the claims and assertions I make within this thesis are located against the background I have just presented. Whilst I aim to present my findings in an unbiased and balanced manner, I believe that complete objectivity is not easy to achieve. To balance out the subjectivity of this study, I hope that my reflexive accounts will facilitate the reader's judgement of the study.

² Victimology or victimological refers to the victimisation (process) of one group of people (e.g. orphans) by another group (e.g. academics)

Chapter 1 - Positioning the young carers project

“It sometimes feels as if there are two epidemics: one being described by the press and government agencies, the other being lived and resisted in the communities most affected by the effects of HIV infection and disease.” (Watney, 1989:18)

Introduction and chapter overview

As the above quote suggests, the representations of communities affected by HIV/AIDS, as described by the press and government agencies, do not necessarily correspond to the realities lived and experienced by the people concerned. This chapter seeks to discuss the academic and peer reviewed literature and explore how it describes the epidemic and its impact on children. The literature review reflects the study aims outlined in the introduction, and seeks to draw out the limitations and assumptions about Western conceptions of childhood and mental health that seem to guide the literature and discourse that describe the circumstances of orphaned and caregiving children. The goal of this critical review is to argue the following:

- Some of the existing literature on orphaned and caregiving children in Africa has a tendency to focus on the negative effects of orphanhood and caregiving and generalise from these findings. This focus and generalisation undermine the fact that many OVC are often competent social actors who are actively coping with difficult social circumstances with skill and ingenuity.
- This generalisation is often underpinned by dominant and Western conceptualisations of childhood, which could be argued to be inappropriate to some African contexts. If one starts from the assumption that a ‘normal’ childhood should be characterised by innocence and play, it could be further argued that one potentially casts African children, whose life circumstances reduce their opportunities for innocence and play as ‘abnormal’, and potentially ‘troubled’.
- There is only a short step from viewing these childhoods as ‘abnormal’ and these children as ‘troubled’ to representing them as children suffering from psychosocial distress. Whilst losing a parent can be a highly stressful situation, psychosocial distress must be understood with an appreciation of how culture and poverty mediate the psychosocial well-being of children, thus allowing us to move beyond the language of psychopathology.
- My overall argument is that instead of focusing predominantly on young carers in terms of vulnerabilities and risks (I will use the focus on their mental health as an example), we should also look at the ways in which some children manage to cope. With this background we can develop interventions that focus on strengthening latent coping strategies and resources.

In doing this I will present and discuss two general lines of inquiry related to the psychosocial well-being of young carers. The first, and more dominating body of literature, approaches orphaned and caregiving children in Africa with an understanding childhood that encourages a focus on the negative effects of their circumstances. The second and smaller body of literature I will be presenting, and to which I align myself, accepts that childhood vary from one context to another and thus looks at their circumstances and agency within a social context – opening up the possibility to focus on children’s resilience and coping strategies. In this review I will be presenting both lines of inquiry, but in a way that builds up my argument. Having said this, a few limitations to this review must be declared. Firstly, I acknowledge that this binary position oversimplifies the complex circumstances that leave young carers both vulnerable and resilient in different ways. Secondly, my subjective opinion will remain clear in the narrative. Thirdly, only the English language literature has been considered for this thesis. Possible concurrent debates in the Spanish, French or other language literature have therefore not been considered. Finally, I acknowledge that literature can have an impact that is disproportionate to its size. Some of the minority literature I align myself to may therefore not be small in its impact.

I start the review with a brief account of the debate that surrounds the conceptualisation of childhood and how children are being represented. This will be followed by a discussion of OVC representations – discussing the influence of dominant understandings of childhood in constructing orphanhood as problem, cost and burden to society and their guardians. These representations will be debated in relation to the living and foster arrangements typical to SSA, pointing towards the reciprocity of care which characterise many SSA households. This takes me to a more comprehensive review of young carers research in UK and Africa, outlining the need to move beyond victimological representations of young carers. As mental health research is establishing a foothold within the OVC literature, including that of young carers, a review of psychological research on children affected by parental bereavement and ailment in an AIDS context will be reviewed. Literature outlining the conceptual difficulties of cross-cultural mental health research on children will also be presented. Before concluding with a set of research questions, I look at how CCCT (as described in my introduction) can be used as an intervention to promote the psychosocial well-being of children and adults within a community.

Through these reviews, the chapter presents the foundation for current research relevant to young carers, and will outline gaps and areas of research that require further investigation, giving rise to a set of research questions that have guided this study.

1.1 Constructions of childhood

The starting point of my thesis is that some (not all) of the existing literature on orphaned and caregiving children in Africa is guided by assumptions about what constitutes a good and normal childhood. According to Boyden (1997) and Edwards (1996), Western understandings of childhood, and the concept of a ‘good childhood’, have become globalised through policies, child rights debates and international development. Before I look at the consequences and dangers of this

development in relation to OVC research, the following sections will examine some of the more nuanced and theoretical understandings of childhood available in the literature. These so-called 'new social studies of childhood' form the conceptual backdrop of my argument and will place the majority of OVC literature into perspective.

The primary goal of 'new social studies of childhood' is to argue and show that understandings of what constitutes childhood vary from one context to another. As Hutchby and Moran-Ellis argue (1998:6) "Childhood is not a natural phenomenon or fixed stage of life, but a historically and culturally variable social construction." We do not have to go to Africa to reflect on changes in conceptions of childhood. Both Aries (1962; 1992) and Zelizer (1994) have written outstanding accounts of the evolution, or discovery of childhood in the Western world during the 19th century. Zelizer (1994:96) traces how children evolved from their 19th century role as contributors to the household economy, to their 20th century status as economically "worthless", but emotionally "priceless", with children being increasingly narrowly confined to the institutions of family and education. Aries (1962) also made note of the role of institutions such as the school and health services as they (e.g. teachers and health professionals) increasingly saw, and constructed, childhood as an age of dependence and vulnerability.

What transpired from this evolution and change to how childhood is perceived is that childhood is seen as a care-free period characterised by play and innocence. Some argue that such Western notions have come to carry normative weight in studies of children cross-culturally (Boyden, 1997; Katz, 1996) and impact the way in which OVC research and interventions are approached by international researchers and local professionals (Meintjes & Giese, 2006). Kesby et al. (2006) further argue that by drawing on dominant understandings of childhood, researchers undermine important nuances of local understandings of childhood in response to poverty and HIV/AIDS.

According to Hutchby and Moran-Ellis (1998) adults across the world acknowledge the competence of children in ways that seem culturally appropriate at a particular historical moment. Thus, for example, children as young as five in urban Madagascar (Sharp, 1996) and rural Tanzania (Porter, 1996) are often responsible for important household tasks such as fetching of water and meal preparations. These tasks and responsibilities highlight a blurring of child-adult boundaries, which is relevant to my discussion on young carers. This has been noted by Evans and Becker (2009:244) in a Tanzanian context, who argue that "children's roles in caring for parents/relatives with HIV conflict with hegemonic Western notions of childhood as a protected phase when children should be free to play with their friends and go to school without having to think about responsibilities associated with 'adulthood'."

Critical social scientists, like Holton (1978), argue that stark distinctions (e.g. child-adult, male-female) are central to sustaining the unequal social relations that can be found in Western societies and maintain global inequalities. Drawing on Holton's (1978) argument, this can be exemplified through existing research on young carers in Western countries that problematise the fact that they are expected to make use of stereotypically adult traits or virtues (such as cooking and nursing

care) as part of their caring responsibilities. Such responsibilities blur the boundaries of conventional child-adult distinctions and lead to a situation where such children are regarded as problematic, and labelled as welfare categories that have been robbed of their childhood³, in need of adult and professional support as well as scientific exploration. Whilst this might arguably be appropriate and helpful for some young carers, particularly those living in the UK, both in the light of dominant understandings of childhood and also due to the availability of resources to support such children in a relatively affluent country, I argue that this process of labelling may be less helpful in other cultural contexts where conceptualisations of child-adult boundaries vary, and where resources available to help such children are limited.

Drawing on dominant conceptions of childhood across cultures and contexts may well impact on existing (local) social representations of childhood. At a grassroots level in African settings, this means that outside 'experts' from overseas development organisations come to define and talk about the needs of children, irrespective of their lived experiences. This danger has been reflected upon by Clauser (1997) who, in an academic and policy debate about street children in developing countries, reflects on his study of street children in Paraguay. In a debate running parallel to my thesis, Clauser (1997) argues that people do not form concepts themselves but internalise those which are hegemonic within their society. In effect, those with power can define the reality of others by socially constructing a language which makes it possible to talk and think about issues that affect, for example, young carers, an argument theorised by Habermas (1987). The theory is that if policy makers and service providers were to use the term, some young carers would take on this identity in an attempt to get support, yet it is an identity of victimisation and vulnerability that can have deeply disempowering consequences. This theory suggests that there can be a potential practical danger when service providers transfer concepts reflecting dominant conceptions of childhood. Although this may occur with the best of intentions, a more cynical Clauser (1997:154) would argue that many of the actions provided by health professionals and academics only attend to their own interests, with a "need to purge a sense of social guilt or to find a field of application of 'good ideas' about what should be done for the needy, more than they benefit the children they work with." Notwithstanding this potential danger, the position of this thesis is that many young carers in SSA *are* in need of support. However, the support that is offered should be framed by a greater recognition of how some children actively manage to cope with their circumstances.

This section has highlighted a flourishing critical trend in the 'new social studies of childhood' where writers and editors such as James and Prout (1997) and Holloway and Valentine (2000) highlight the way in which conceptualisations of childhood vary across time and culture. The forthcoming section will highlight some of the representations of OVC in Africa and explore how these representations are shaped by the authors' own understandings of childhood.

³ Numerous newspaper headlines have referred to young carers as children with no childhood e.g. 'Robbed of their own childhood' (by Clark, 2007 in the Daily Mail) and 'Give the young carers their childhood back' (by Baldwin, 2006 in the Yorkshire Evening Post)

1.2 The representations of OVC in Africa

“A key problem in the literature on the impact of orphanhood on the well-being of children, families and communities, is that the focus of assertions and predictions is often on the negative impact of ‘AIDS orphans’, or households.” (Andrews et al., 2006).

In line with Andrews et al.’s (2006) observation, this section provides a critical examination of the representations of orphanhood held by some academics, service providers and multilateral organisations. I do this to support my argument that much OVC literature represent OVC as incompetent, troubled and dependent beings in need of support and only few studies frame their circumstances in light of their competence and active role in society.

The growing number of OVC has resulted in a surge of well-intentioned research exploring the needs of OVC. Although the HIV prevalence has fallen in many SSA countries (UNAIDS, 2008), the long incubation period between infection and illness, and the fact that HIV infection rates only reached their peak in the mid-1990s, has led UNICEF (2003:10) to predict that “the worst is yet to come.” Although AIDS deaths have fallen globally as a result of improved access to treatment, 75% of all AIDS deaths in 2007 occurred in SSA (UNAIDS, 2008). Thus, although HIV infection rates have levelled off in many SSA countries, the estimated figure of 12.1 million orphaned children in the region will continue to grow (UNICEF, 2008a). However, before researchers and service providers frame their responses to these alarming statistics, it is useful to 1) acknowledge that orphan statistics available from UN documents have been argued to over-estimate orphan figures by 30 to 50% from national demographic health survey figures (Bennel, 2005) and 2) explore the definition of orphanhood more closely.

In the Introduction I highlighted some of the different definitions of orphanhood found across countries. However, the predominant working definition of orphanhood in both the academic and grey literature is a child below the age of 18 years who has lost one or both parents (Skinner et al., 2006). One can therefore assume that many of the 12.1 million orphaned children reported by UNICEF still have a living parent. A literature review carried out by Foster and Williamson (2000: 275) of orphan literature produced in the 1990s states that “most estimates and models define an orphan as a child whose mother has died.” This indicates a shift of definition over time. It is often reported that maternal orphans continue to be worse off than paternal orphans (Kang, Dunbar, Laver, & Padian, 2008; Nyamukapa & Gregson, 2005; Timaeus & Boler, 2007). Also in the Bondo district of Kenya, the location of this study, Nyambedha et al. (2003a) found that maternal orphans were considered more vulnerable than paternal ones. UNICEF (2004) warns that as more women get infected and die from AIDS, the disease will change the pattern of orphaning in SSA with maternal orphans outnumbering paternal orphans in near future. Curiously, the finding that maternal orphans (where children still have a father) are worse off than paternal orphans (where children still have a mother) is in conflict with a study from South Africa, which observed substantial benefits of orphaned children living with their father (particularly to their education) and a limited importance of maternal orphanhood (Timaeus & Boler, 2007). Similarly, research has found that female-headed households are worse off than male-headed households (Huisman, 2005; Katapa, 2006). Such

discrepancies indicate not only a lack of reliable data, but also the complex circumstances that characterise many African contexts and households. Nevertheless, returning to the definition of orphanhood and the discussion of whether children who still have a living parent should be referred to as orphans, Andrews et al. (2006) are of the opinion that children who have lost a parent to AIDS should be referred to as orphaned children. They argue that in the wake of HIV/AIDS, it is likely that the other parent is infected and soon unable to contribute to the household (ibid.).

Whilst this may be the case for some households, the statistics used to describe orphaned children reflect a pessimistic view that places a focus on parental absence even before the death of the living parent. Meintjes and Giese (2006) are of the opinion that more emphasis and attention should be paid to the role and presence of the living parent and other fostering arrangements. Reflecting the importance of fostering arrangements, recent findings from Manicaland in Zimbabwe, found that a third of maternal orphans reported their 'mother' to be alive in a follow-up survey. Whilst the child's biological mother may be deceased, a female relative or community member can take on parental responsibilities and thus be the child's social mother (Robertson et al., 2008). Whilst such arrangements can leave children vulnerable to exploitation, they can also provide good and nurturing relationships that may deem it inappropriate to refer to such a child as an orphan, in the social sense.

In response to what many believed was an overly narrow definition of orphanhood in the context of HIV/AIDS, the construct of OVC was introduced. Nevertheless, it has been argued that OVC in reality still refers to children affected by AIDS and has done little to provide a more nuanced account of children's circumstances in Africa (Meintjes & Giese, 2006). This is evident in UNICEF's 'Children on the Brink' report, which defines 'vulnerable children' as children whose survival, well-being, or development is threatened by HIV/AIDS (UNICEF et al., 2004). This definition effectively excludes children caring for parents who are disabled or ill of diseases unrelated to AIDS. This obviously has implications for the support which might be available to this group of children, who are presumably no more or less in need of help and support than children more directly affected by AIDS.

This focus on orphanhood and the conceptualisation of OVC as victims of the AIDS epidemic is at the core of much child-centred policy and research in Africa. Fassin (2008) attributes this focus to the innocence and vulnerability with which children have become associated, further revived by fears and prejudices related to AIDS. It is a conception which is proliferated by the media (Lupton, 1994; Meintjes & Bray, 2005) and to a certain extent academic discourses (Patton, 1999). Academia is known for its intellectual debates and whilst this is also the case in research related to orphaned and caregiving children in Africa, much of it is influenced by Western ideologies that essentialise categories, such as childhood, without allowing for an understanding of historical meanings (Boyden, 1997; Edwards, 1996). This is exemplified in an anecdotal account of the experiences of 9-year-old 'AIDS orphan' Bwalya by Michael J. Kelly (2003:61):

“The World Summit for Children has affirmed that childhood should be a time of joy and peace, of playing, learning, and growing. But for Bwalya, as for millions of the children of Africa, the reality of childhood has been altogether different. Coping repeatedly with death, grief, and mourning, without mother or father to give care and loving attention, moving from one home to another, not knowing how long the present situation might last, Bwalya’s childhood has been anything but laughter-filled, innocent, and happy. His experiences have aged him before his time, transforming him into a ‘juvenile adult’ – vulnerable, scarred, and wary of life.”

Whilst I do not disagree that many children are scarred and wary of their circumstances, my belief is that Bwalya’s case is a worst case scenario and that most of the children witnessing similar experiences to Bwalya cope with the situation and do not turn in to ‘juvenile adults’. The quote constructs a stereotypical picture of ‘millions of children in Africa’ whose representation could be argued to do little to support these children. Similarly, Barnett and Whiteside, two prominent social science AIDS researchers have been quoted as referring to orphaned children as “unsocialised, uneducated, in many cases unloved and struggling to adulthood”, predicting a crime-wave as the children grow up (Barnett and Whiteside in Fassin, 2008).

These quotes touch on a number of socially constructed conceptualisations of childhood, bereavement, and not least, the psychosocial distress of orphaned children. Similar representations of ‘vulnerable African children’ are evident elsewhere. UNICEF (2004) for example states that children, following the death of a parent, are at increased risk of malnutrition and illness, less likely to get medical care, more likely to be withdrawn from school and to be deprived of money and property that belongs to them. Whilst some of these assertions are undoubtedly true to some children in certain contexts, such narrow representations ignore the plurality of experiences.

In support of UNICEF’s assertions, Oni (1995), in his study on fostered children in Nigeria, found orphaned children to be less likely to access medical care, a finding also noted by Nyambetha and colleagues (2003a) in Western Kenya. Whilst orphaned children may be disadvantaged to medical care, this is not necessarily reflective of their health status. Lindeblade et al. (2003) found that the impact of orphanhood on the health and nutrition of Kenyan children is greatest among children younger than 6 years of age as they are more dependent on adults to provide them with food, shelter and care. But by looking at orphaned children as a group, Lindeblade et al. (2003) conclude that there is little difference in the health status of orphaned to that of non-orphaned children. This is reiterated by Sarker et al. (2005) who in neighbouring Uganda found that there were no major effects on orphan status on health and nutrition.

With regards to education, numerous observers have documented the many negative impacts of orphanhood on children’s school attendance and performance (Case, Paxson, & Ableidinger, 2004; Robson & Kanyanta, 2007). A 5-year study of 20,000 children in Kenya for example found school participation to decrease substantially following parental death (Evans & Miguel, 2007), an observation I have also made in Kenya (Webale, Skovdal, Mwasijaji, & Tomkins, 2009). However, Bennel (2005:467), following a review of the literature on the impact of orphanhood on education,

states that “the impact of losing one or both parents on education attainment is often much less than has been suggested.” This is exemplified in a recent study in Burkino Faso, which found orphaned and non-orphaned children equally likely to be enrolled into school (Pagnier et al., 2008) and from Tanzania where Ainsworth, Beegle and Koda (2005) found minimal impacts of parental death on schooling of 1,213 orphaned children. Highlighting the multifaceted circumstances that impact on orphan schooling, Nyamukapa and Gregson (2005) studied the difference of orphan status in safeguarding education. They found maternal orphans to be less likely to attend school than their non-orphaned peers, but paternal and double orphans as likely, and in certain cases, more likely to attend school than their non-orphaned peers (ibid.).

Despite the contrasting and nuanced research available, some of the more powerful organisations working for OVC in Africa continue to focus on the negative effects of orphanhood. UNICEF’s 2005 report on *The State of the World’s Children* for example is titled *Childhood Under Threat* and former UN Secretary-General Kofi A. Annan writes in the foreword that “for nearly half of the two billion children in the real world, childhood is starkly and brutally different from the ideal we all aspire to” (UNICEF, 2004c:vii). The report has got the best of intentions and advocates for some very serious issues that undermine children’s well-being by following a rights-based approach and continually refers to the Convention of the right of the child. In Chapter one of the report, UNICEF (2004c:1) distances itself from critics who dismiss the utopian conviction “that the majority – let alone all – of the world’s children could actually experience such childhood as the ideal that infuses the Convention, one of love, care and protection, in a family environment, with ample scope to survive, grow, develop and participate.” UNICEF goes on to argue that “swift and decisive action is required to reduce the poverty that children experience, protect them from armed conflict and support those orphaned and made vulnerable by HIV/AIDS. Everyone one of us has a role to play in ensuring that every child enjoys a childhood.” The report also argues that “the world must reaffirm and recommit to its moral and legal responsibilities to children. For governments and donors, the message is unambiguous: Keep your commitments to children. Children’s rights must be given highest priority” (UNICEF, 2004c:87).

In my view, children are not the problem, but part of the solution. Despite being a critic, I do share UNICEF’s commitment and ideal to improve the well-being of children. However, I do not share their inclination to draw on Western and dominant understandings of an ‘ideal’ childhood, resulting in a representation of the ‘deviance’ of poor communities in the developing south. I believe the utopian ideal is more feasibly achieved through an acceptance of their culture, circumstances and capacity for active participation. This acceptance must consider all the ecological layers that contribute to their circumstances, allowing health professionals to target and draw on existing coping strategies evident within their social context.

If we fail to do so, there is only a short step from viewing OVC as ‘troubled’ and ‘abnormal’ to representing them as children deprived of a protective upbringing and who are suffering from poor mental health. There are examples of where this is already happening. UNAIDS, for example, published a report in 2001 on how to give psychosocial support to children suffering from the

trauma of losing a parent, drawing on existing programmes in Zimbabwe and Tanzania. The programme in Tanzania was organised by UNICEF and facilitated by a local NGO (Humuliza). The programme involved the training of health officials from six districts in Tanzania on the psychosocial support of orphaned children. The curriculum included training on parental bereavement and grief and concepts like risk, vulnerability, protective mechanisms and stress, trauma, coping and resilience (Humuliza, 1999).

Whilst I share the commitment to provide vulnerable children with much needed social and financial resources, I am less convinced about the need for scaling up mental health programmes. Another example of how the negative effects of orphanhood are being translated into a focus on their mental health is the initiative by The Regional Psychosocial Support Initiative for Children affected by AIDS, Poverty and Conflict (REPSSI). REPSSI works with over 140 local NGOs in eastern and southern Africa and train psychosocial support course leaders. REPSSI (undated) was established by two men who both “shared the same central concern: children who were traumatized by the loss of their parents and also suffered economic and social disadvantages as a result of being orphaned were in need of psychological support as well as material assistance” (Schmitt, 2008).

There are numerous other small-scale initiatives, such as that by the Kitovu Mobile AIDS organisation operating in Uganda, who runs a mobile counselling programme, targeting OVC. They say: “Counselling is best known for its ability to soothe the pain which people go through especially in the era of HIV and AIDS scourge. It is a psychological (inner struggles) treatment that works upon a person's mind / soul or spirit to enable him/her think positively and in the long run causes healing in the mind and body” (Kitovu, undated).

Initiatives like that of UNICEF, REPSSI and Kitovu are only some of the many projects endorsed by the World Federation for Mental Health who has set up an Africa initiative that works to make mental health a priority in Africa. Unsurprisingly, also work with young carers has been dominated by a focus on their psychosocial distress. Evans and Becker (2009), for example, found in Tanzania that many service providers felt it was important to provide emotional and psychosocial support for young carers to relieve stress and reduce their sense of isolation. In fact, five of the seven organisations participating in their study offered some kind of emotional support to young carers. Similarly, in Zimbabwe, Martin (2006) reports on a programme by the Island Hospice Service in Harare, which involved young carers in grief workshops (8-10 sessions for each child), and covered topics such as coping with grief, caring (worries, fears, challenges), sexual abuse, memory work and family history. The purpose of these sessions was to help them with recent or forthcoming losses as well as talking about their difficulties in caregiving.

As the above paragraphs suggest, a number of steps have already been made from viewing these childhoods as ‘abnormal’ and ‘troubled’ to representing them as children suffering from psychosocial distress. I want to use mental health as the example of the literature that predominantly focuses on the negative effects of orphanhood and AIDS. To further highlight the

discourse that surrounds OVC, the next section will explore the living arrangements of OVC and ask the question, 'Are OVC a burden or a benefit?', a question that is relevant to the reciprocity of care and support, which characterise many households with orphaned and caregiving children.

1.3 The living arrangements of OVC – a burden or a benefit?

Representing orphaned children as a group that inevitably has disproportionate physical and emotional needs, highlights the cost orphaned children add to their fostering home and society more generally. Ennew (2005) for example argues that orphaned children continue to be represented as a particular burden and cost to their guardians and Fassin (2008) argues that the victimological image of orphaned children gives a terrible picture of South Africa's future. He has observed that AIDS orphans are represented as delinquents or street children and therefore a potential danger for national as well as international security, representations, he argues, are rooted in compassion, fear, history and the unconsciousness.

Unsurprisingly, research into the burden of orphan care in Africa is flourishing with studies reporting increases of anxiety (Ssengonzi, 2007), stress (Oburu & Palmerus, 2003, 2005) and financial hardship (Nyambedha et al., 2003b) faced by caregivers. The anxiety reported by elderly caregivers in Uganda was related to their inability to pay for school related expenses, full-time caregiving of younger orphans (below the age of 6 years) and care for children living with HIV/AIDS (Ssengonzi, 2007). This echoes the findings of another study in Uganda, which found elderly caregivers to face the hardship of accumulated costs, both related to time and money (Williams & Tumwekwase, 2001). In Kenya, Oburu and Palmerus (2003, 2005) found limited instrumental support and perceptions of children's behaviour, and the strategies used to discipline orphaned children, as stressful for elderly orphan caregivers. Also in Kenya, Nyambedha and colleagues (2003) discuss the 'new role' of elderly caregivers based on their finding that elderly caregivers struggle to meet the costs related to schooling, health care and food for orphaned children. They refer to the added responsibilities given to elderly people as a 'lost retirement'.

However, the fostering role of grandparents is not new phenomenon in Africa. Many African children have spent large parts of their childhood away from their parents in an effort to strengthen family kin ties and spreading the costs and benefits of children (Caldwell & Caldwell, 1987; Lloyd & Desai, 1992; Serra, 2009). Fostering of children by grandparents is still as common as it used to be. In SSA 46% of older adults live with a grandchild, of which only 1.7% are children who have lost both their parents (Zimmer & Dayton, 2005). It is therefore clear that even without the AIDS epidemic, grandparents, past and present, play a key role in fostering children. More recently, the coexistence of different motives (e.g. child getting foster care and foster family benefiting from child's labour) and reciprocities of care and support have been discussed and highlighted (Abebe & Skovdal, in press; Serra, 2009; Skovdal, in press).

Nevertheless, despite the normative role of grandparents fostering children, the AIDS literature tends to focus on the burden of orphan fostering, which in turn contributes to the perception that

extended families, particularly ageing grandmothers, are being 'overwhelmed' by parentless children (HelpAge, 2008). Much focus is given to the problems associated with this perceived wave of orphaned children stretching and burdening traditional safety nets such as that of grandparents. Foster (2000) is of that perception, and warns us of the possible consequences of orphaned children slipping through traditional safety nets and end up on the streets. Whilst this is most certainly the case for some children in certain circumstances, this is not representative of all and present a one-sided focus on the social cost of 'lost retirement' and potential 'juvenile' and 'scarred' street children, at the expense of an understanding of how children actually contribute to the household and on occasions benefit their guardians.

In fact, there are a number of anthropological accounts that testify that children's work and support to their household is an important part of their socialisation, particularly for children from rural and farming communities (Abebe, 2007, 2008; Abebe & Kjørholt, 2009; Katz, 1996; Raum, 1940). Children as young as five have been identified to be responsible for important household tasks, including cooking, fetching of water, caring for other children and errand running (Porter, 1996; Sharp, 1996). According to Katz (1996), their participation in household activities facilitate the children's early sense of responsibility and belonging, an observation also made by Sharp (1996) in Madagascar, who found children's work in the household to be a result of collective responsibility, duty and love, a perspective which researchers writing about orphaned children in a context of HIV/AIDS largely ignore from their work. It can be argued that the large number of children residing with grandparents is a testimony of the benefits children bring to the elderly in a region of the world where old-age pensions are a rarity (Serra, 2009). These observations highlight children's active contribution to sustaining household livelihoods.

There appears to be a conceptual gap between the anthropological literature that views working children as social and active participants that offer benefits to their households, and to that of the OVC literature (AIDS and policy focused) which has a tendency to represent OVC as a burden. Existing OVC literature does not pay enough attention to, for example, the anthropological literature, which suggests that their assumptions are too narrow. Only few researchers, writing within the context of HIV/AIDS, have bridged these conceptual differences and documented the benefits of children's contribution to their households. Ansell and colleagues (2004) have usefully coined together the needs and circumstances of fostering households and the capacities of children, highlighting not only children as social agents, but also the reciprocal relationship that characterises guardians and their fostering children. Also Abebe (2007, 2008; 2007; 2009), through his case study of working children in Ethiopia, paints a more nuanced and contextual picture of orphan care and reciprocal relationships, emphasizing the role children play in their fostering household. This study aligns itself with this emerging body of research that views children as social actors and thereby challenges the dominant discourse, which without a contextual understanding, continues to view orphaned children as passive victims who burden their guardians. This suggests a need to better understand and contextualise the real caring and living arrangements of OVC in SSA (Hill, Hosegood, & Newell, 2008; Van Blerk & Ansell, 2007) and in particular the reciprocity of

care evident in fostering households (Abebe & Skovdal, in press; Evans & Becker, 2009; Howard et al., 2006; Serra, 2009; Skovdal, in press).

This study will therefore celebrate and strengthen the small, but growing body of research that counters the more negative stereotypes of children and place greater emphasis on some of the more positive attributes of orphaned and caregiving children. To strengthen this trend, the focus on this study will be to look at the coping strategies of a particular group of children (young carers) who engage in work that might be considered culturally inappropriate, both by some inhabitants of their communities, but predominantly by outside observers. This focus will not only enhance our understanding of the active role children play in helping families and communities cope with disease and poverty, but also develops a complex understanding of how the children often facing extremely difficult circumstances, cope with these responsibilities. The next section will explore the existing literature that surrounds young carers.

1.4 Young carers research

In the previous section I argued that dominant understandings of childhood may impact on how some research with children in Africa is conducted and in so doing lead to a predominant focus on the negative outcomes of their circumstances. This section will review the young carers literature available from the UK and the developing South and explore how this literature represents young carers. I will then transfer and extend the critical arguments made by the disability movement in the UK to an African setting, providing a framework to approach young carers as active and social participants who cope and need to be recognised as such. Again, this is not to say that young caregiving is desirable, but to encourage a shift in focus that will allow us develop more appropriate support strategies.

1.4.1 Experiences from the UK

Young caregiving became topical in the 1990s when Margaret Thatcher made informal caregiving a duty of kinship, friendship and neighbourhood. Caregiving subsequently became a hot topic on the social policy agenda, which culminated with the implementation of the Carers Act in 1995 (DOH, 1995). A survey carried out on behalf of the Department of Health in 1996 defines a young carer as “a child or young person who is carrying out significant caring tasks and assuming a level of responsibility for another person which would usually be taken by an adult. The term refers to children or young people under 18 years caring for adults (usually their parents) or occasionally siblings.” (Walker, 1996).

Aldridge and Becker (1993, 1997, 2003) from the Young Carers Research Group (YCRG) at Loughborough University, together with other researchers, have been at the forefront in influencing social service departments, Department of Health and NGOs in the UK in bringing attention to the needs of young carers. With the introduction of *the Journal of Young Carers Work* by YCRG, young

carers really hit the academic discourse and soon became a topic frequenting the media (e.g. Baldwin, 2006; Clark, 2007).

“Being a young carer is portrayed in almost wholly negative terms in the literature.” (Olsen, 1996:44)

As noted by Olsen (1996), and in line with my earlier discussion of how ‘childhood’ is constructed, research on young carers in the UK has a focus on the detrimental effects of their circumstances. Studies of children caring for parents with diseases as diverse as diabetes, HIV/AIDS, cancer and mental disorders testifies to this trend (see Aldridge & Becker, 1999; Cooklin, 2006; Evans & Becker, 2009; Gates & Lackey, 1998; Gray, Robinson, & Seddon, 2008; Jacobson & Wood, 2004). Some of these effects include problems at school, finishing off homework and obtaining qualifications (Bibby & Becker, 2000; Dearden & Becker, 1998; Evans & Becker, 2009; Underdown, 2002), health problems (Becker, Dearden, & Aldridge, 1998; Coombes, 1997; Doran, Drever, & Whitehead, 2003) and emotional difficulties, isolation, and restricted opportunities for social networking (Aldridge & Becker, 1993; Dearden & Becker, 1998), as well as poor mental health (Cree, 2003; Pakenham, Bursnall, Chiu, Cannon, & Okochi, 2006). Similar outcomes have been observed in the United States where there are an estimated 1.4 million young carers (Hunt, Levinde, & Naiditch, 2005; Shifren, 2009). Alongside this negative portrayal, a few studies in the UK (Becker, 2000), North America (Beach, 1994; Blackford, 1999; Gates & Lackey, 1998) and Australia (Pakenham, Chiu, Bursnall, & Cannon, 2007) have also observed some positive effects of young caregiving, including maturity and the development of a sense of responsibility and self-worth. While this study does not deny that the negative effects exist for some young carers, it argues that the extent and focus on the detrimental outcomes for young carers potentially contributes to the victimisation of this group of children, a trend recently admitted to by Aldridge and Becker, who in the 1990s, narrowly researched the needs of young carers (cf. Aldridge, 2008; Becker, 2007; Joseph, Becker, Becker, & Regel, 2009).

Nevertheless, the focus on the negative effects of young caregiving also impact on the representations of young carers in the media. On June 10 2009, the Press Association of the UK released a news bulletin titled ‘Study highlights struggle for ‘hidden’ young carers’. This release was followed up on by 11 British newspapers⁴ on the same day with titles such as ‘Damning report says children who devote their lives to sick parents have been abandoned’ (Daily Mail), ‘Being a young carer makes you grow up faster than you realise’ (Western Mail Wales), ‘Child carers take punishment at school in silence’ (The Independent), ‘Young carers struggle to cope’ (Daily Post Liverpool) and ‘Young Carers are a forgotten group’ (Derby Evening Telegraph). These titles give detail to how research and policy reports continue to be translated into victimological representations in the public sphere.

Despite a recent commitment to move beyond the needs and difficulties of young carers, the early efforts by Aldridge, Becker and other researchers are good examples of how influential research

⁴ According to a Lexus Nexis search

can be in affecting social policy and public opinion, which in turn has direct implications on how young carers are represented. However, not everyone has been in favour of portraying young carers in negative terms.

The disability right's movement has been vocal, arguing that the majority of research on young carers positions them as victims and presents an implicit and explicit criticism of the parent and their parenting (Keith & Morris, 1995; Olsen, 1996). Although the disability movement believes it is important to highlight the rights of young carers and their disadvantaged situation, they believe identifying young carers as a 'welfare category' does nothing to prevent young caregiving (Morris, 1997) and ignores other variables that impact child well-being such as poverty, unemployment, poor housing and social class (Olsen, 1996). Their argument is that it is the parents who need help, firstly to have their rights and needs met, and secondly to help them acknowledging that placing certain tasks and responsibilities on children are inappropriate (Morris, 1997; Olsen, 1996).

Parents receiving support from their children have also engaged in the debate. Keith and Morris (1995:43), for example, are disabled mothers who assert that "our children are not our 'carers', they do not parent us; but the social construction of 'young carers' and the media attention which has followed affects us every time we go out with our children, every time we meet new people, especially health and social services professionals. The research and media representation of 'children as carers' undermines our role as mothers and defines disabled parents as inadequate."

Reflecting such views, Richard Olsen (1996, 1999, 2000), representing the disability movement, has taken a front position in challenging the alleged 'facts' about young carers, and the hidden assumptions buried in the way in which they are conceptualised in research and the media. Olsen (1996) highlights the different experiences of caring, arguing that only a third of young carers in the UK care for a parent. Others are involved with the care of a grandparent, care for a sibling, or are involved with more domestic work (as opposed to nursing care) for a number of different reasons, all of which suggest that young caregiving is more nuanced and complex than the discourse currently represents (*ibid.*). Olsen (1996) usefully asks how the experiences of young carers differ from those that might be called 'non-caring' children, challenging the assumption that 'non-caring' children have access to all social, educational and developmental opportunities. He further asks what constitutes a 'normal' childhood? And when does care become care work? Perhaps the children wish to care for their parent and do not want anyone else to take that responsibility. Who are the 'carer' and the 'cared for'? It can be argued that caring may be reciprocal and the child is both the carer and the cared for (Horwitz, Reinhard, & Howell-White, 1996), an observation I have also made in Kenya (Skovdal, *in press*)

Olsen (1996:45) has also commented on the assumption that young carers' 'lost childhood' compromises their psychosocial well-being, arguing "there is an uncritical assumption in the literature that taking on caring tasks leads to psychological or emotional damage in children." With such representations, from a social constructionist perspective, arguing that subjective experiences are shaped and mediated by the social processes and discourses, it may be no surprise that Bolas

et al. (2007) found a strong sense of negative 'otherness' amongst young carers, contributing to a sense of social exclusion and limited social participation. Young carers naturally draw on the 'stories' developed to them to give their circumstances meaning in relation to others (ibid.). As these 'stories' are partly developed by the media and the academic discourses, it highlights the importance of countering these negative stereotypes with some positive attributes and the danger of adopting the existing young carers discourse to Africa. In the context of Kenya, this thesis will explore the meanings and identities of young carers and see how these impact their ability to cope.

In this section I have highlighted the way in which the dominant discourse of young carers in the UK has tended to focus on the difficulties facing young carers, and the way in which the disability movement has put forward a more complex and nuanced view, one that seeks to challenge the dominant discourse of young carers in the UK. This nuanced view has more recently been translated into a focus on resilience and coping. According to Becker (2007) such a focus will encourage researchers and policy makers to consider new ways of understanding the experiences of young carers, namely as an active expression of resilience. Due to the socioeconomic and cultural differences between the UK and African countries, young carers research in Africa may assist this process (Evans & Becker, 2009), outlining the role and relevance of this study. The next section will explore the existing young carers research in Africa and review how it helps us develop a more advanced understanding of young carers.

1.4.2 Young carers in Africa

There has been little recognition of the role children play in providing care and support for their ailing and ageing guardians in SSA. This is despite the fact that Foster and Williamson (2000:278) stated, already in year 2000 that "research is needed into the impacts, both negative and positive, that caring has on children, the needs of children as caregivers and the ways in which disruptions to schooling can be minimised." The limited literature on young caregiving in Africa that has emerged *is* reflective and provides a balanced account of the positive and negative outcomes of young caregiving. Nevertheless, whilst most of the existing literature on young carers in Africa acknowledges the problematic nature of childhood, it could be argued that it still sides with the dominant and earlier discourse of the UK by focusing on the negative effects of young caregiving. With only one study exploring the resilience of young carers in Africa (cf. Evans & Becker, 2009), this section will suggest that there is an urgent need for further and innovative research.

Literature searches on young carers in Africa only generate a handful of peer-reviewed journals (see Bauman et al., 2006; Martin, 2006; Robson, 2000; Robson, 2001, 2004; Robson et al., 2006), two book chapters (Bauman & Germann, 2005; Robson & Ansell, 2000) and a book (Evans & Becker, 2009). Aside from my project, other on-going research on young carers includes a project by a team of researchers from the University of Oxford who have set out to explore the physical and mental health and educational outcomes of 3000 young carers aged 12-18 in South Africa (Cluver, undated).

Research on young carers in Africa was initiated by Robson and colleagues, who, following the focus and policy interest of young carers in the UK, were led to ask: 'What of young carers in the South?' (Robson & Ansell, 2000). All available research on young carers in Africa has been carried out in Zimbabwe, Tanzania and Lesotho. Nobody has yet looked at young caregiving in Kenya.

Robson and colleagues have usefully mapped out the circumstances of young carers, including the problems they are facing (see Robson, 2000, 2001, 2004; Robson & Ansell, 2000; Robson et al., 2006). These include disruption of schooling, loss of friends and isolation, difficulties looking after an ailing person and the wider household and trauma as a result of caring and bereavement (Robson et al., 2006). In addition to identifying the problems faced by young carers, they have also outlined the potential benefits of young caregiving, such as learning new skills, developing close and loving relationships with the person they care for, and growing up as a mature and responsible person (Robson et al., 2006). Supporting one of the arguments of this proposed study, Robson et al. (2006:107) reiterate: "It is worthy of note, however, that young caregivers voiced some benefits of having the responsibility, even the privilege, of caring for a loved one." For a more comprehensive list of the positive and negative outcomes identified from a sample of nine caregivers see Table 3 for details.

Table 3: Costs and benefits to young caregivers and their households (Robson et al., 2006)

Costs	Benefits
<i>For individual young caregivers</i>	
Educational Costs: <ul style="list-style-type: none"> • Disruption/termination of schooling or post-school training 	Education Benefits: <ul style="list-style-type: none"> • Learn new skills – listening & patience, home nursing
Personal Costs: <ul style="list-style-type: none"> • Loss of friends, isolation • Tiring demands & difficulties of looking after a sick person 	Personal Benefits: <ul style="list-style-type: none"> • Grow up – become strong, take responsibilities & decisions, experience life, gain maturity • Fun & enjoyment – occupation during school holidays
Emotional Costs: <ul style="list-style-type: none"> • Trauma of facing illness and/or death of loved one • Emotional costs of caring & grief of bereavement 	Emotional Benefits: <ul style="list-style-type: none"> • Close loving relationship between carer and care recipient – sharing stories & life experiences. • Emotional maturity & pride in caring
<i>For Young Caregivers' Households</i>	
Reproductive Costs: <ul style="list-style-type: none"> • Neglect of other household members, e.g. young siblings 	Reproductive Benefits: <ul style="list-style-type: none"> • Domestic tasks undertaken as part of caring
Income Costs: <ul style="list-style-type: none"> • Young carer unable to do paid work to support household 	Income Benefits: <ul style="list-style-type: none"> • Household does not have to pay for care assistance • Allows other household members to work

In addition to the positive and negative outcomes of caregiving, Robson and colleagues have also pointed towards the circumstances that characterise young caregiving in an African context. For example, they found that caring roles varied greatly from domestic farm work tasks to more personal care of bathing, feeding and toileting and that girls were observed to care more often than boys (Robson & Ansell, 2000). The meanings that the children ascribed to their circumstances led Robson and Ansell (2000:190) to question the transferability of the term 'young carers' to the South

and prompt the question of “whether it is meaningful or useful to define the Zimbabwean young people describing their experiences of caring as ‘young carers’.” Similarly Robson and Ansell state: “To impose on these Zimbabwean students the definition of ‘young carer’ is perhaps to pathologise the activities in which they engage” (ibid.:191).

Robson (2004) has also tied young caregiving in Africa to geopolitical factors, arguing, quite rightfully, that support of young carers in Africa should be channelled through national responses to HIV/AIDS in the support of whole families caring for an ill member, moving the attention away from young carers as an isolated welfare group. In doing this she also argues that young carers should be recognised as child workers and so with the right to recognition of their work as work. Robson challenges Western notions of childhood and defends children’s rights to work under appropriate circumstances (ibid.).

However, Robson remains ambiguous in her messages. Despite her critical engagement with the term ‘young carers’ as a Western construct, which may be inappropriate in Zimbabwe, she also states that many children find themselves burdened by caring beyond what is socially expected from them and therefore the term ‘young carers’ is, despite being produced in the West, an appropriate term to describe caregiving children. Furthermore, in conceptualising young carers as child workers (see Robson, 2004), it could be argued that Robson conforms to Western understandings of childhood as a time of innocence and play. Lastly, while Robson’s (2001) paper on the ethical issues she encountered during research with young carers is important and reflect a very real concern for anyone working with young carers, it can be argued that the paper’s focus on how distressing the interviews were for her respondents, portrays young carers as emotionally scarred and fragile. Although the paper reflects the very real tragic circumstances facing some young carers, Summerfield (2000, 2004) has warned against the short step from seeing and portraying children as sad to them being perceived as psychologically scarred.

Nevertheless, Robson and colleagues have, academically, covered the essential milestones of confirming the existence of young carers as a group worth investigating, and raised important questions of the conceptualisation of ‘young carers’ in Africa and highlighted that children’s caregiving experience do not have to be detrimental. Their observations have facilitated and guided the development of my proposed study.

Another study guided by the initial observations of Robson and colleagues is a recently completed comparative study (see Evans & Becker, 2009). With ESRC funding, Evans and Becker set out, in 2006, to compare the experiences of children caring for parents with HIV and AIDS in the UK and Tanzania (ibid.). Acknowledging that children with caring responsibilities do not necessarily experience physical, emotional, relationship or other psychosocial problems, Evans and Becker draw on a resilience framework, providing a useful counterpart to a focus on risk and problems. Involving 15 children in Tanzania and 9 children in the UK, Evans and Becker outline some of the resilience and negative impacts of care work as described by the children within their families, the school environment and the wider community. Aside from identifying problems of stigma, poverty,

poor physical and emotional health, social isolation and poor academic performance, Evans and Becker (2009) also identify the importance of supportive school environments, young people's friendships and supportive social networks. They conclude that researchers need to move away from a focus on the 'vulnerability' of young carers to one concerned with 'resilience' (Evans & Becker, 2009). This is a good starting point to explore in greater detail the coping strategies, processes and resources that help young carers cope with challenging circumstances.

In what could be argued to be a less critical comparative study between Zimbabwe and the US, Bauman and colleagues (2006) interviewed a total of 100 ill mothers with HIV/AIDS and one of their children. The study objectives were to answer who provides care, how often do children care, and what are the consequences for children to provide care, including the depression levels of children. As the study was quantitative, a number of scales were used, including: the psychiatric symptom index, children's depression inventory, the conflict behaviour questionnaire and the inventory of parent and peer attachment. Although these questionnaires were adapted to the study, they arguably reflect the assumption of the authors: That caring for an ill parent is a traumatic experience for both mother and child and that it has psychological consequences, focusing on the negative experiences. While this undoubtedly is true for some, it is an assumption which I argue reflects the Western medicalisation of suffering and life challenges, which Summerfield (2004) will refer to later in this chapter. Although the study found that 63% of Mutare children had clinically significant symptoms of depression, this was not correlated to caregiving (Bauman et al., 2006). It could be speculated that the observed high depression rates and the fact that 8 out of 10 Mutare children say they have too much responsibility, may in fact just reflect strategic answers given to the researchers in hope for support. Perhaps more importantly, they found the bond between child and parent to be an important predictor of child mental health and further stated that children may in fact benefit from helping to make a parent feel better. Nevertheless, in this study the authors have brought together the terms 'young carers' and 'mental health' despite a lack of evidence to suggest that child caring per se is a risk factor for psychological dysfunctioning. They claim that child mental health services are insufficient and rare in Mutare and that the children's psychological pain requires urgent intervention.

Similar conclusions have been made by Martin (2006), also in Zimbabwe, who reports on a programme by the Island Hospice Service in Harare. The programme involved young carers in peer-group sessions and grief workshops, providing them with the space to talk about their caregiving role and parental bereavement. One youth volunteering on a programme for young carers said: "These children need psychological support to deal with the situation that can be totally unbearable." (Martin, 2006:123).

Informal conversations with social science research colleagues and NGO contacts in Africa suggest that numerous studies on young carers in Africa are currently underway, mirroring the same mental health discourse, and that one can expect their publication in the next couple of years (e.g. Cluver, undated). The research by Cluver and her team, for example, is guided by their conviction that "children caring for their AIDS-unwell parents are potentially at high risk for negative outcomes in

mental and physical health, education and sexual health” (Cluver, undated). The link between young caregiving and psychosocial distress also takes precedence in the only study on children caring of parents with AIDS in China (Zhang et al., 2009).

Although the young carers literature in Africa has contributed to a more nuanced debate on young caregiving, I will continue to develop my argument that much of the expanding literature on young carers in Africa focuses on the negative effects of young caregiving, compounded in studies looking at the needs and difficulties of young carers - often described with reference to the psychosocial distress of young caregiving. I will do this by moving beyond the limited literature on young carers and look at the psychological research on orphaned children.

1.5 Links between orphanhood and psychological trauma

I have thus far outlined some of the ways in which orphaned and caregiving children are represented in the literature and how this has led to a focus on the negative effects orphanhood, particularly to their mental health. The link between orphanhood and psychosocial distress has been made before. For example, in the post-war context of Sri Lanka, Argenti-Pillen (2003) draws a link between the negative social construction of orphanhood by international aid agencies and local professionals and the perceived risk that the majority of orphaned children of war might develop mental illnesses and suffer from post-traumatic stress.

This section will explore this link further in the context of HIV/AIDS in Africa by first reviewing some of the existing AIDS literature that looks at the psychological impact of orphaned children in Africa. This will be followed by a discussion of the relevance of a mental health discourse in Africa. In so doing I hope to draw attention to the way in which the focus of the psychological vulnerability of orphaned and caregiving children is socially constructed and use this as the foundation for a re-conceptualisation of their psychosocial well-being.

1.5.1 Psychological impact of orphanhood

A large body of academic literature focuses on the psychological impacts of orphaned children in the context of issues such as living with HIV infected parents, parental bereavement and orphanhood, as well as social challenges such as stigma. Much of this research has been conducted in Western Anglophone countries such as Australia, the UK and in particular the US where a great deal of literature suggests that children of parents with HIV/AIDS are at risk of mental health problems (Bauman et al., 2009; Levine, 1993; Rotheram-Borus, Stein, & Lin, 2001; Rotheram-Borus, Weiss, Alber, & Lester, 2005). Some of these mental health problems refer to anxiety and depression (Bauman & Germann, 2005; Lester et al., 2006) and emotional and behavioural problems (Nostliner, Bartoli, Gordillo, Roberfroid, & Colebunders, 2006).

The death of a parent is an ubiquitous experience which most people at some point in their lives must confront. Much literature on parental bereavement has been generated since Freud's (1957)

article 'Mourning and Melancholia'. According to Rotheram-Borus and Lightfoot (2000), clinicians between 1990-2000 produced over 500 articles arguing that parental death has a substantial negative impact on adolescents psychological well-being, and losing a parent to AIDS has been found to be especially difficult (Rotheram-Borus et al., 2001).

It is therefore no surprise that the literature on the psychosocial impact of orphanhood in Africa has increased significantly over recent years. I now turn to examine this literature in order to highlight:

- i) How OVC research is guided by dominant understandings of childhood, leading to a focus on children's psychological well-being.
- ii) The limitations of looking at the psychosocial problems of children in many parts of rural Africa, including a preference of researchers to use Western tools and conceptualisations of mental health – reflecting a victimological starting point.

The available literature has boomed over the last decade. In 2001, a review by Wild (2001) identified eight studies looking at the psychological outcomes for orphaned children, of which only two looked at orphaned children in Africa. Five years later, Cluver and Gardner (2007a) did a follow-up review of the literature and found that the number of studies looking at the psychological outcomes of orphanhood had increased to 24 and with an increased focus on SSA. All hypothesise and conclude that children who are orphaned by AIDS will show a higher incidence of psychological difficulties. Cluver and Gardner (2007a) also report that there are a number of additional and ongoing and unpublished studies from Africa confirming the psychological vulnerabilities of AIDS orphans. This rapidly growing trend contributes to the discourse affecting the young carers debate and requires a closer look. I will now turn to discuss some of the studies that give detail to psychosocial distress experienced by orphaned children.

Using a 25-item depression assessment Sengendo and Nambi (1997) found, that AIDS orphans, in particular those living with a widowed father, were sad, felt anger, had little hope for the future and scored high on the depression scale. As a result, the authors recommend the involvement of child psychologists and social workers in schools to offer guidance services. Similar conclusions were drawn from Makame et al. (2002) in a case-control study in Tanzania. All children were interviewed using a semi-structured questionnaire which included an internalising problem scale. The scale had 21 items that were selected from the Rand Mental Health Inventory and the Beck Depression Inventory. In addition, all children were given the Wide Ranging Achievement Test to give an indication of school achievements. Although orphaned children scored markedly higher than non-orphaned children on the internalising problem scale, predominantly due to food insecurity and poor school attendance, the orphaned children were not rewarded less in school or at home and neither were they given excessive domestic chores or punished more than non-orphaned children (ibid.). Interestingly, although Makame et al. (2002:463-4) in their discussion claim that internalising problems can be reduced significantly through economic relief to for example cover needs such as food security and school fees, they persistently conclude that "there is obviously an urgent need to

expand and improve current programmes, not only to meet the basic needs of orphaned children but also to include psychosocial support with counselling services.”

Similarly, using the Beck Youth Inventory with 123 orphaned and 110 non-orphaned children in rural Uganda, Atwin et al. (2005) found orphaned children to have greater risk of anxiety, depression and anger. Following the above findings, it is perhaps of no surprise that orphaned children have also been connected with Post-Traumatic Stress Disorder (PTSD) (Cluver & Gardner, 2006). Cluver and Gardner have been actively involved in framing and conceptualising the psychosocial distress of orphaned children (see Cluver, undated; Cluver & Gardner, 2006; Cluver & Gardner, 2007a, 2007b; Cluver et al., 2007). In their study of 30 orphaned children and equally many controls, they did not observe any difference between orphaned and non-orphaned children with regards to conduct problems, peer relations, hyperactivity and emotional stability (Cluver & Gardner, 2006). They did however find orphaned children to have scored 73% above the cut-off point for PTSD – but where this cut-off point is, is scientifically problematic and questionable (Summerfield, 2001a). Although Cluver and Gardner (2006) acknowledge the limitations of the study and “the limited evidence” which it presents, they still claim the need for psychosocial intervention and more large-scale research into mental health of orphaned children.

More recently, Ruiz-Casares and colleagues (2009) used the children’s depression inventory to explore the association between orphanhood and depression. They distributed the inventory to 157 school pupils in three regions of Namibia. The study claims to have found evidence that orphanhood is associated with mental ill health, but acknowledges that it has a small sample size and limited power. The most powerful study linking orphanhood with psychosocial distress was carried out in Zimbabwe (Nyamukapa et al., 2008). Using questions from the Child Behaviour Checklist, Rand Mental Health Inventory and Beck’s Depression Inventory, the survey included the responses of 5,321 children. Although the authors acknowledge the limitations of drawing on these questions in a Zimbabwean context, they still conclude that orphaned adolescents suffer greater psychosocial distress than non-orphaned and non-vulnerable children. However, unlike many of the above studies, Nyamukapa et al. (2008) do not recommend counselling services, but highlight the association between poverty and social connectedness, suggesting the need to alleviate poverty and facilitate social support that enables OVC to stay in households with close relatives.

Most research into the psychosocial well-being of OVC reflects the studies reviewed above. However, five studies have usefully explored the coping and resilience of orphaned children in Africa, giving some indication of the importance of closeness and competence in a social context in building resilience (Daniel, Apila, Bjorgo, & Lie, 2007; Evans, 2005; Evans & Becker, 2009; Fjermestad, Kvestad, Daniel, & Lie, 2008; van Dijk, 2008). I seek to contribute to this small but emerging trend of exploring the psychosocial well-being of OVC by looking more specifically at the hitherto unexplored group of young carers. While I am not denying that OVC may be more likely to suffer from psychosocial distress, what transpires from the above literature is that scales and measurements produced and tested in Western contexts are repeatedly used in radically different socio-cultural contexts. The psychological scales are used by a thriving research community who

draw on negative stereotypes of OVC, often with limited evidence. On the basis of the above studies, I argue that academics looking at the mental health of OVC are largely driven by assumptions of victimhood as opposed to 'survivorhood'. Below I seek to map out the context in which this emphasis has arisen.

1.5.2 The development of an 'African mental health' discourse

Spearheaded by the World Health Organisation, global mental health is fast on the agenda. In 2007, the *Lancet* published a series of articles on global mental health, arguing that every year 30% of the world's population will develop some kind of disorder, urging the need for scaling up mental health services world wide (Horton, 2007). However, this view is challenged by Derek Summerfield (2000, 2004, 2006, 2008) and other academics (Argenti-Pillen, 2003; Kirmayer, 1989; Kleinman & Good, 1985) who argue that Western definitions and solutions in mental health cannot be routinely applied to people in developing countries. Such views correspond with the classical argument of Edward Said (1979; 1993) who states that indigenous knowledge systems are being undermined and overruled by more dominant and Western knowledge systems that despite seemingly good intentions, is of disadvantage to local populations.

According to Summerfield (2004) since the European Enlightenment psychiatric science has been seeking to convert human pain, misery and madness into technical and standardised terms, which are universally applicable and subject to interventions by experts – a point that echoes the work of Foucault et al. (1972). This has created a flourishing mental health industry, which commodifies health, requiring the identification of new needs and desires, making people believe that experiences like bereavement and bullying, require professional intervention (Summerfield, 2004).

Since the inclusion of PTSD in the third edition of the Diagnostic and Statistical Manual of Mental Disorders, it has been used widely and enthusiastically to describe reactions to trauma in different settings (Bracken, Giller, & Summerfield, 1995). Summerfield (2001b:95) argues that this label has been accepted too quickly and used too widely by the international research community without a critical understanding of its social construction: "Post-traumatic stress disorder is an entity constructed as much from socio-political ideas as from psychiatric ones."

This is especially true cross-culturally. As Kleinman and Good (1985) note, cultural worlds may be so different that the translation of emotional terms from the studies of Western psychiatrists to the lives of children in Africa will require an additional analysis of what it actually means to be a person in the lifeworld under study. A lack of such analyses may undermine the validity of some mental health studies of OVC in Africa. Although it is a challenge, Canino and Alegria (2008:237) urge clinicians drawing on a universal framework for mental health "to consider culture and context in determining the way in which children's psychopathology may be manifested independent of their views." Against this challenge, a number of people committed to improving the mental health of people in low and middle income countries have indeed made attempts to adapt and validate mental health measures in local contexts (Patel, 1998; Pereira et al., 2007; Prince et al., 2003).

These studies suggest the need and highlight the importance of understanding local expressions and responses to suffering, a task this study has set out to explore in relation to young caregiving in East Africa. It is therefore crucial to consider the cultural background of orphaned and caregiving children to develop an understanding of their circumstances and meanings. In this thesis I consider local understandings of childhood and child/adult relationships in an attempt to understand the expressions and responses of young carers.

Nevertheless, if the critique held by Summerfield and other mental health specialists (e.g. Argenti-Pillen, 2003; Canino & Alegria, 2008; Kirmayer, 1989; Kleinman & Good, 1985) in a range of countries and contexts have any strength, this casts serious doubts on the validity of much of the research outlined above. It is therefore worrying when Li et al. (2008) actively facilitate this trend by largely drawing on the writings of Western bereavement and grief to present a developmental psychopathology framework for AIDS orphans in resource poor settings, highlighting the need for psychopathological research and intervention.

An often neglected practical danger of Western conceptualisations of mental health is that the more prevalent the technologies in therapeutic treatment become in the wider society, the more people come to learn that they are not expected to cope through their own resources and networks (Summerfield, 2004). This observation by Summerfield is important to this study for two reasons. Firstly, socially constructed representations form the symbolic field in which people construct their social identities and meanings. Secondly, these social identities and meanings impact on how children formulate their responses to difficult life experiences and social problems. For example, if orphaned children are diagnosed, or increasingly referred to as children suffering from post-traumatic stress, this may shape the way in which they, as 'victims', feel recovery is achieved and where to get support. In essence, the more a society sees the trauma of orphanhood as a serious risk to their future, as well as present, well-being, the more it may well turn out to be. As trends in mental health expenditure in the industrialised West indicate, this may already be the case in some parts of the world. Stress for example, and in particular work stress, is argued by many to be a socially constructed disease, topping the list of causes for sickness leave in the UK (Wainwright & Calnan, 2002). Pupavac (2001) sees the medicalisation of such vicissitudes as a fundamental shift of the concept of a person in Western society, which now places greater emphasis on vulnerability as opposed to resilience. One historical example, often used by Summerfield (2004), shows that vulnerability has not always been at the forecourt of human concept. In 1966, a tragic accident hit a school in Wales. During heavy rains, the school was engulfed with coal waste, killing 144 school children. In response, emphasis at the time was to get back to normal, counselling was not provided and compensation or prosecution were not demanded. Months later, a child psychologist concluded that survivors appeared normal and well-adjusted. If a similar incident was to happen today, survivors would be assumed to be traumatised by the experiences. A case in point is the 2004 Beslan siege in Russia in which 338 people, half of which were children, got killed. In the aftermath, UNICEF supported mental health experts from all over Russia in working with children in Beslan to sharing their knowledge with local counsellors. UNICEF's Representative in Russia, Carel de Rooy, is reported to have said: "There is a lot of trauma to be dealt with [...] obviously the scars will never

go away completely” (UNICEF, 2004b). This example indicates a shift, fed by the mental health industry, from a focus on resilience to one of vulnerability.

Using Western understanding of mental health, as well as Western psychological measures, may therefore be detrimental to people in developing countries (Bracken et al., 1995). First of all, the core problem facing many orphaned and caregiving children is poverty, and studies exploring the mental health of OVC do little to bring attention to the real structural problems that cause poverty. Moreover, orphaned and caregiving children may through psychosocial distress studies and NGOs, become informed about new vulnerabilities. Summerfield (2004) would argue that these new vulnerabilities run the danger of replacing the real vulnerabilities of poverty, vulnerabilities that should be tackled through poverty reduction and community mobilisation strategies that target all poor members of a community.

I mentioned earlier that subjective experiences are shaped by the socially constructed representations of their situation. The classifications and labels used to describe children of particular circumstances provide them with the conceptual tools through which they give meaning to, and organise themselves in relation to others. If these meanings are victimological and focus on vulnerability as opposed to resilience, this can have an impact on how orphaned and caregiving children perceive their lived realities and are expected to handle vicissitudes. The potential impact of terms referring to the vulnerability of orphaned children has been discussed by Meintjes and Giese (2006) who found that the professional (Western) use of the term orphan and orphanhood had shifted the terrain of orphanhood and produced new struggles at a grassroots level in South Africa. In their study, they found children taking upon them the identity of an orphan because of its economic valence through the potential support they might receive from international aid agencies. Meintjes and Giese (2006) also found adults describing locally perceived non-orphans as orphans, again because of their economic valence. They warn of the danger of children accepting these representations and orphan identities, arguing that the children might be thrust into the belief that they are indeed vulnerable and in need of support – undermining local responses and coping strategies.

If Meintjes and Giese are correct, social constructions of mental health needs could have the potential to create a paradox where children, in order to be supported would need to learn how to think psychotherapeutically and accept labels such as ‘orphan with PTSD’, ‘traumatised orphan’ or ‘emotionally scarred orphan’. This could indirectly result in the subordination of their local understanding on how to respond to difficult times. They might arguably forcibly take up a formal language reflecting Western and professional discourses which simultaneously teach the children to devalue locally sensible relevancies and contexts, and to downplay their competencies and skills in order to meet the agency definition of orphanhood and vulnerability, a scenario theorised by Habermas (1987) as the ‘colonisation of lifeworlds’.

“Development colonized reality, it became reality.” Arturo Escobar (1992:414)

Arturo Escobar summarises neatly my argument above. The tools, technologies and ideological dispositions used by mental health professionals in Africa, although used with the best possible intentions, may impact the way in which people are expected to cope, undermining socio-cultural ways of enduring and coping. The mental health industry runs the danger of imposing a shift of human concept from resilience to vulnerability, not dissimilar to that already seen in Europe. On this basis the starting point of my own research is that European, American and local professionals that work for the psychosocial well-being of OVC, need to look at their psychosocial distress with a more nuanced and reflexive lens. This should be a lens that depicts the complex and cultural realities of childhood and mental health. It is a lens that will allow professionals to see the conceptual and methodological limitations of focusing on the problems and psychosocial distress of OVC. The aim of my study is to look at OVC with these lenses and explore their psychosocial well-being and coping strategies.

What comes from this review is that there is some promising literature out there, both in relation to children’s participation (e.g. Abebe & Aase, 2007; Abebe & Kjørholt, 2009; Ansell & Van Blerk, 2004; Katz, 1996) and the debate surrounding mental health in Africa (e.g. Argenti-Pillen, 2003; Kirmayer, 1989; Kleinman & Good, 1985; Summerfield, 2000; 2004). What the literature review has also brought forward is the argument is that some of the work by researchers exploring the psychosocial distress of orphaned and caregiving children is situated within Western understandings of mental health and childhood. It was highlighted that a focus on the pathology of orphaned and caregiving children may well influence how society and communities see and describe their problems and impacts on how they seek support and expect recovery. Such socially constructed ‘truths’ and realities could arguably run the danger of becoming self-fulfilling prophecies that can potentially facilitate a mental health crisis.

In this chapter I hope to have raised some awareness of the negative way in which OVC are often referred to in the literature, and drawn some attention to the dangers of this discourse, with a view to promoting a more nuanced representation of orphaned and caregiving children. Against this background, this study aims to:

- Contribute to the strengthening of the ‘good literature’ by providing empirical evidence of how young carers cope with vicissitudes.
- Provide some concrete pointers of the types of social psychological resources that enable or hinder the coping of orphaned and caregiving children.
- Pilot an intervention aimed to support this coping, to investigate and illustrate some of the possibilities and limitations of community-focused approaches.

I do not deny that some orphaned children get depressed and I firmly believe that many OVC are in need of psychosocial support and experience hardship. However, I believe the investigation and support of the psychosocial distress of OVC should look towards the provision of much needed

social and financial resources. Furthermore, existing socio-cultural coping strategies and responses should be strengthened, rather than locating OVC suffering at the level of the individual, undermining the social context. In the next chapter I will explore this argument further and introduce the potential of CCCT.

1.6 Research Questions

In this literature review I positioned the project in relation to the complex and contradictory literature related to children and HIV/AIDS in Africa. I reviewed the literature on orphaned children in Africa and young carers in the UK to highlight the origins and genesis of young carer research in Africa. In addition, the expanding mental health discourse which characterises discussions about OVC and young carers in Africa was reviewed with the aim of bringing to light material closely related to that of young carers, all in the interest of

- mapping out the tendency (in both the northern and southern literature) to problematise young people who fall outside the boundaries of what constitutes 'normal' childhood; and
- to highlight the growing literature that critiques this tendency.

This chapter has developed some of the critiques presented in the minority literature and presented some alternative views to the dominant discourse of orphaned and caregiving children, in particular to develop a more complex and multifaceted view, reflecting the children's experiences, a view that places greater emphasis on coping and positive development and which shifts the level of analysis from the 'individual' to 'individual in context'.

As I have previously said, it is not the aim of this study to dispute the suffering and hardship they face. There are certainly situations and circumstances that are extremely difficult for some young carers and a cause of concern for many. However, as I have argued, it is important to understand that there are consequences from the tendency to generalise from observations at an aggregate level to viewing the majority of young carers as psychologically distressed.

A key aim of this thesis is to contribute to the development of the minority literature, with a particular focus on the active participation and agency of children as they cope with difficult circumstances. However, as children's ability to cope is a result of their interactions with other people, the next chapter presents the social psychological frameworks that will guide this study. I will seek to develop a social psychological conceptualisation of coping which focuses on existing, context specific and community-level coping strategies. According to Campbell (2003) there are two main reasons why community-level analysis is important. Firstly, it is the community which forms the context in which people can make sense of their circumstances by drawing on their social lives and identities. The community is the cross-road between micro- and macro-social levels of analysis. Secondly, the involvement of community members in development projects is generally believed to facilitate ownership and generate supportive and competent communities.

In contrast to the problem-focused research, it is my intention to focus on the social psychological and community-level determinants of coping and outline the complex circumstances that characterise young carers, a thus far unexplored area. Nuanced understandings will allow us to develop interventions aiming to improve the psychosocial well-being of young carers by providing them with opportunities for (i) positive identity construction; (ii) the development of useful skills and knowledge; (iii) enhancing their sense of coherence; and (iv) to link them with more powerful groups and agencies that can help them.

Based on the literature review presented in this chapter and to provide a more refined understanding of the circumstances that characterise young carers and the ways they cope with adversity, this study addresses the following seven questions:

1. What is the nature of their caring roles and responsibilities?
2. What are the psychosocial needs of young carers in Western Kenya?
3. What coping strategies have they developed to deal with their challenging social circumstances
4. What factors facilitate and/or hinder coping?
5. What is the most feasible way of providing psychosocial support to young carers in Africa?
6. What role can community-based capital cash transfer play in strengthening the ability of orphaned and vulnerable children to cope?
7. How can support agencies best work to reinforce existing and latent coping skills in young carers and their communities?

In answering these questions against the literature review presented in this chapter, I concur with Kesby et al. (2006:186) and argue that if the needs of vulnerable children in Africa, like young carers, are to be met, “there is a need to conceptualise ‘other childhoods’ as they *are* and not in terms of what they are not.”

Chapter 2 - Towards a social psychology of coping

Introduction and chapter overview

The previous chapter outlined and critiqued the academic literature on young carers and the mental health of OVC in Africa. A number of issues emerged from the literature review. Firstly, the argument that dominant understandings of childhood can guide a focus on the negative effects of orphanhood was explored. Secondly, it was suggested that the psychological well-being of these children is being measured with Western mental health scales and scores, implying that the discourse of psychopathology is a useful framework for characterising children who engage in caring activities. Thirdly, this focus on the negative effects of orphanhood and caregiving could be argued to overlook the agency and initiative that my own observations suggest that young carers use in getting by from day to day.

With the best of intention, much research is preoccupied with looking for cures and solutions to life demands that are constructed as problems and associated with psychopathology. Although many children are indeed victims of poverty and disease, it is my view that this increasingly overwhelming focus provides a narrow and distorted lens which omits a great deal of useful and actionable information about orphaned and caregiving children and their coping strategies.

Against this background, I have argued that we need to develop more complex and in-depth understandings of their circumstances. We need to explore their coping and resilience-building strategies and learn to identify and strengthen existing strategies to support young carers. This leads to the possibility of facilitating support for this particular group of children, as well as allowing for a recognition of children's agency more generally.

As will be argued in this chapter, most theories of coping focus on the decontextualised individual and seek to generate universal and generalisable conceptualisations of coping processes (cf. Garmezy & Rutter, 1983; Lazarus, 1966). In some respects these theories are useful orienting devices for researchers. However, I argue they are too general to be of much use as actionable tools in a community setting. It is my starting point that coping will always be a context-specific activity – shaped by the particular problem that a child faces, and enabled or limited by the social, political and economic situation in which he or she is located. As a result, children's lifeworlds are not constructed within a vacuum, but negotiated within specific social contexts, highlighting the need to develop a social psychological understanding of coping that includes community-level factors at the heart of its analysis. Such an understanding would see coping as a process through which children and community members actively negotiate and provide support in specific social settings. It is therefore the aim of this chapter to provide a framework for conceptualising the social psychological resources that might facilitate such coping and generate context-specific

understandings that are useful for researchers and service providers seeking to support children in a SSA context. In summary, at least three reasons will be identified as to why it is important to develop a social psychological understanding of coping.

- 1) A social psychology of coping shifts attention from the individual to the individual-community interface, which I will argue plays a key role in shaping the possibility of coping and resilience.
- 2) It provides a lens through which the agency and active participation of individuals and communities can be explored. This has practical ramifications for how we conceptualise and work with marginalised communities using a strengths-based approach.
- 3) It opens up the possibility of facilitating the development of more effective and context specific policies and practices.

As already stated, the aim of developing a social psychological understanding of coping is related to my motivation to generate research which highlights the social psychological resources through which community members and service providers can facilitate supportive social environments. In framing coping within a community setting, Campbell's concept of 'AIDS competent communities' (Campbell, Nair, & Maimane, 2007; Campbell, Nair, Maimane, & Gibbs, in press) will provide a useful heuristic tool for starting to explore the social psychological resources that can facilitate coping at a community level. I will therefore use Campbell's AIDS competent community as a starting point to develop my own model of 'orphan competent communities' (OCC). As social capital permeates the fabric of many social psychological resources, I will integrate Woolcocks (1998, 2001) policy framework on social capital into my elaboration of the dimensions of an OCC.

A key goal of my empirical research in this thesis is to give content to the notion of OCC, understood as a context which maximises the likelihood that orphaned and caregiving children will be able to cope with adversity. In this chapter I will therefore introduce the way I sought to develop this concept. My final conceptualisation, the outcome of my empirical research, will be presented in Chapter eight.

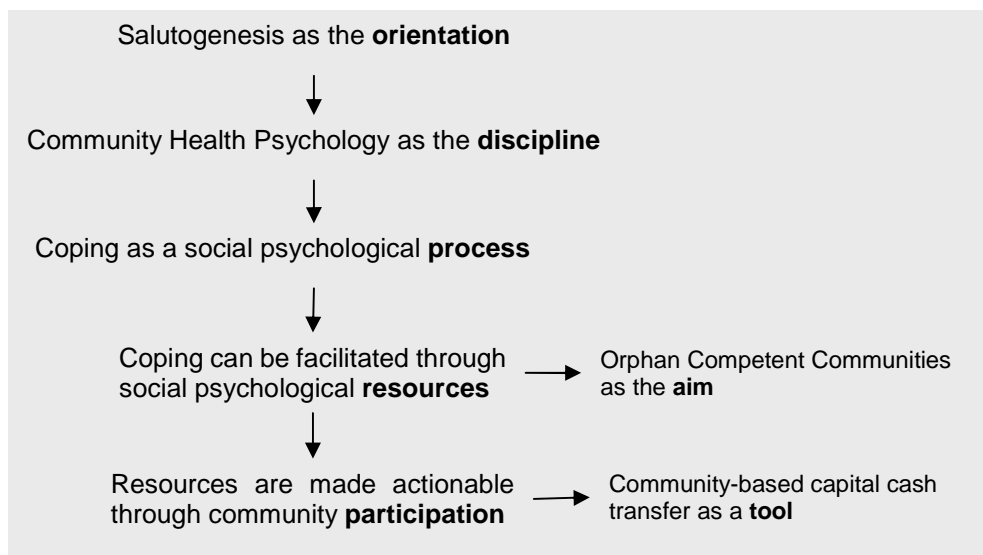
To build this theoretical framework, a number of concepts and theories will be integrated, adapted and reframed (see Figure 1). The chapter consists of five sections. To contextualise this theoretical framework and provide a rationale for the inclusion of these concepts and theories, this first section of this chapter starts off by exploring the orientation which directs the thesis, locating it within a public health discourse. The second section provides a detailed overview of existing conceptualisations of coping and resilience, highlighting the need for a social psychology of coping.

The third and core section of this chapter outlines the social psychological resources, or dimensions, of Campbell's notion of AIDS competent communities that might be relevant to OCC and explores how they might impact on the coping of young carers. Many of these social psychological resources are best promoted through the participation of community members (Campbell, 2003). For this reason, the fourth section explores some of the pathways between

coping, participating and OCC. To do this I explore the potential of participatory learning and action cycles, as described by Rifkin and Pridmore (2001), for strengthening the social psychological resources that facilitate resilience and coping of children and their communities. Sparked by my more general interest in facilitating local responses through a successful interaction of bottom-up and top-down approaches, this section will also explore the potential for community-based capital cash transfers, as actionable interventions facilitated by NGOs, can provide communities with the social psychological resources (through participation) and financial capacity (a vital ingredient of the intervention) to build OCC.

Before concluding, the fifth and final section of this chapter highlights and discusses some of the potential limitations of facilitating OCCs through community participation. To summarise the integration of these theories and concepts into a theoretical framework, Figure 1 presents a flow diagram, which links the theories and highlights the flow of this chapter.

Figure 1: Flow diagram of theoretical diagram



2.1 Locating a social psychology of coping in a ‘public health discourse’

It is the aim of this first section to indicate the schools of thought that gave rise to this thesis and the development of a social psychological framework of coping. This section thereby provides some background and context to some of the assumptions I may make in this, past and forthcoming chapters.

2.1.1 The new public health

In the previous chapter I critiqued the work of Bauman and Foster et al. (2006), Cluver and Gardner (2006, 2007a; 2007) and other researchers that although guided by science and well-meaning intentions, seemed to be unaware of the socio-political implications of their work. Such work, ascribing negative characteristics to poor and vulnerable African children, fall under what Petersen and Lupton (1996) call the ‘new public health’.

Petersen and Lupton (1996) sees this development as an outcome of regimes of power and knowledge that are aiming to regulate and exercise surveillance over individuals and their social bodies. The ‘new public health’ places great emphasis on documentation, classification and measurements, changes that require a specific type of knowledge and expertise of ‘the other’ (e.g. African children).

This is relevant to this study for two reasons. Firstly, all of the literature discussed in this thesis is by adults who write about children. Secondly, the majority of authors are Western who speak about the circumstances in Africa. According to postcolonial theory, this phenomenon has come from the need of the West to construct the ‘non-West’ (in particular Africa) as ‘other’ and ‘a problem’. According to Park (forthcoming), such contrasting images and constructions of ‘the other’, is an integral part of Western identity, contributing to a fundamental ‘othering’ of Africa and a felt need to help ‘poor’ and ‘primitive’ African children. One consequence of the West constructing such an identity is that it projects back on how Africans (or children) may see themselves (Mohanty, Russo, & Torres, 1991; Said, 1979). As mentioned in the previous chapter, this has practical implications at a grassroot level when imposed understandings of orphanhood shift the local terrain in which support is negotiated. Arturo Escobar (1992) argues that we need to move beyond the normal vision of the ‘Third World’ (especially Africa) as in need of ‘development’ to a celebration of difference of cultures, the relativity of history, and the plurality of perceptions, a move to which I seek to contribute.

Foucault has previously talked about the governability of social fields. He has demonstrated the role of human sciences in regulating populations as he observed humans becoming the objects of the

exercise of power in wake of new specialist knowledge such as psychology and medicine (Foucault, 1977). I will argue that the growing body of mental health research on orphaned and caregiving children is a reflection of this regulatory development by specialists, whether it be for a 'new public health' (Petersen & Lupton, 1996) or so-called development 'gaze' (Foucault & Sheridan, 1979). In this argument, NGO workers, researchers, policy makers, human rights activists and child psychologists conceptualise and represent young carers as objects 'at risk' and in need of intervention/control. A possible effect of this development 'gaze' is that young carers across the world, often without their knowledge, can be defined, monitored and supported by external agencies and professionals through the prism of a particular conceptualisation of childhood and young caregiving, something that my research seeks to problematise by looking at their coping strategies and resilience and far more complete lived realities.

Whilst I do not deny the many benefits of the 'new public health' industry, or the development 'gaze' to improve the health and well-being of people, I believe that a debate on the moral, social and political implications of such science and developments is important and can point to new directions of research. One area that could be brought forward in human sciences, and that can contribute to the aforementioned debate, is the role of contextual knowledge in international development. One of the dangers of the 'new public health' crossing cultures (in this case from Western to African contexts) is the risk of regulation, and the introduction of terms and classifications, extending into families and communities whose contexts, worldviews and experiences may be profoundly different.

2.1.2 Knowledge in context

The way in which researchers understand and describe a phenomenon, for example young caregiving, does impact on policy and possibly the way children see themselves. As a result, policy developed about and for young carers may promote social identities that may not reflect the meaning that children themselves, and their communities, give to their experiences. It is against this background that McDonald (2009) argues for the involvement of children in the research process, bringing forward *their* voices rather than the representations that may be held by the researchers in the way children are conceptualised and understood.

There is also a need to acknowledge the representations within a context. If these representations, and their context, are ignored, it could be argued that there is a danger that international aid agencies and researchers working with orphaned and caregiving children may shrink or distort the children's social reality to a reality objectified by the organisation. In their investigation of the importance of social identities in policy, Hockey and James (2003:90) have noted that children, and indeed representations of childhood, are shaped by policy as a "conceptual category and social identity that is given material form in everyday life." Similarly, Taylor (1998) argues that policy focused research often creates and sustains both negatively and positively valued identities. It could be seen as a concern that the majority of research into the circumstances of young carers in the UK is problem-focused, leading both journalists and researchers to focus on the negatives of

young caregiving in the UK (as discussed in the previous chapter). This may shape the social identities of young carers in the UK and how this group of children is approached in Africa.

In Chapter one I introduced the work of Meintjes and Giese (2006), which illustrates how some orphaned children in SSA have taken on more Western understandings of orphanhood in order to benefit from international aid agencies. They argue that these representations have shifted the local terrain in which support is provided and negotiated. Such constructions have the potential to create a paradox where children, in order to receive external support, would need to learn how to think organisationally and accept labels such as 'OVC', 'orphan', 'young carer' or 'street child'. This could indirectly result in the subordination of their local understandings of themselves and the terminologies of life processes real to them. They could inadvertently be pressurised to take up a formal language reflecting Western and professional discourses which simultaneously teach the children to devalue locally sensible relevancies and contexts (Habermas, 1987).

The 'new public health' industry in developing countries involves more than securing and promoting the health and well-being of people. It is an industry driven by resources, technologies and conceptualisations from economically more advanced countries, which, although arguably driven by good and philanthropic intentions, is still part of an underlying development industry whose aim is to 'lift up' developing countries to the level of the 'developed' countries of the North, with Northern countries being seen as the norm that so-called 'developing' countries should aspire to. According to Escobar (1992) this is an enterprise which is still in place and despite the development industry's many failures, it still treats many countries in the South according to their 'Third World' status and their dependence on the goodwill of the 'First World', its multinationals, capital, technology and development agencies.

Technology and the development industry have indeed improved health and made available lifesaving vaccines and treatments to millions of people in the majority world (UNICEF, 2007). However, these successes and many more would be greater if the tendency by development agents and public health specialists to 'know best' did not undermine local knowledge and representations and included those in their efforts to improve health and well-being (Campbell, 2003; Campbell & Jovchelovitch, 2000; Jovchelovitch, 2007). As highlighted in Chapter one, this tendency has also been identified in the mental health industry where Summerfield has expressed concerns about the role and impact of the Western mental health industry in Africa, for example through the pathologisation of children (Summerfield, 2000, 2008).

This discussion suggests that researchers cannot pretend that their work is neutral. A social psychology of coping addresses some of the moral, political and social implications of the current public health discourse, as described above, by focusing on existing strategies and local knowledge, encouraging a dialogue and negotiation between 'professionals' and community members.

The forthcoming section will highlight the guiding orientation this framework will adopt in framing a social psychological understanding of coping.

2.1.3 Salutonic orientation

Although attention to local knowledge and context is vital for an understanding of how young carers cope, this should be guided by an orientation that seeks to highlight effective adaptation in difficult circumstances. Antonovsky (1987, 1990) developed such an orientation and named it salutogenesis (Latin for the origins of health).

Antonovsky developed the term after following a group of central European women who had been born between 1914 and 1923. Some of these women had spent considerable time in concentration camps during the Second World War and many, despite being subjected to horrific experiences and trauma, had come to terms with their experiences and carried on with their lives (Antonovsky, 1987). Antonovsky asked himself how that was possible. It was this question, the search for health and coping, that gave rise to his conceptualisation of salutogenesis, a conceptualisation that would allow public health professionals to move beyond post-Cartesian dualism between mind and body and look to imagination, love, play, will and the social structures that foster coping and successful adaptation (Antonovsky, 1987). This essentially opened up a focus on the possible meanings that could explain how people cope with vicissitudes.

As an orientation, salutogenesis does not guarantee solutions to situations of hardship and the complex dynamics of human existence, but it does search for more profound understanding and knowledge of coping and well-being, a good starting point for moving toward better health (Antonovsky, 1987). This thesis does not seek to develop specialised techniques or suggestions about how outside professionals can cure the stress and hardship faced by young carers through expert techniques such as psychotherapy. Instead it seeks to report on existing indigenous life strategies, developed by young carers themselves within their immediate communities, that promote movement toward coping and well-being. The thesis also seeks to conceptualise a context (OCC) that can be used to explore and strengthen community-level strategies.

As discussed in Chapter one, much of the research guiding the psychological well-being of OVC is focusing on the negative effects of orphanhood. In these studies, researchers, practitioners, and policy makers were looking at how specific disorders can be measured and diagnosed. As Antonovsky (1987) notes, such disease-focus can lead to mounting wars against particular diseases, disorders and groups of people, a tendency I outlined in Chapter one with regards to OVC and their psychosocial distress. Salutogenesis on the other hand, makes us focus on the challenge of active adaptation to difficult circumstances, highlighting survival and agency as opposed to defeat and victimisation.

This orientation to health and well-being compels us to look at coping and enhancement of resilience building factors. Thinking salutogenically opens up for new ways to conceptualise coping

and having adopted this orientation I was led to formulate a social psychology of coping. A salutogenic oriented discipline within the public health arena, which this framework will draw on, is community health psychology, a discipline that looks at the root causes of injustice that impact on the health of disadvantaged and marginalised groups of people, and seeks to understand the possibility of facilitating the active role of such people in efforts to challenge and ameliorate the impacts of negative social settings on their well being (Campbell & Murray, 2004; Nelson & Prilleltensky, 2005).

2.1.4 Community health psychology: building health-enabling community contexts

Alongside this gloomy view of the 'new public health' by Petersen and Lupton (1996) mentioned earlier, runs a more optimistic conceptualisation of a 'new public health' (see Baum, 1998). The 'new public health' which Baum talks about, refers to a twenty-first century move from medical models of public health to an approach which places greater emphasis on the socioeconomic and cultural influences of health seeking and preventive behaviour. Community health psychology as a discipline has been at the forefront in this trend, arguing for a new public health that promotes positive community participation, based on the theories of conscientisation, social identity, social representations and power (Campbell & Jovchelovitch, 2000; Murray, Nelson, Poland, Maticka-Tyndale, & Ferris, 2004). Community health psychology arose in response to a dominant health psychology which too frequently ignored the way in which individual determinants of health were shaped by a broader social context (Campbell & Murray, 2004). Echoing the salutogenic orientation, people within community health psychology want to move away from the pathogenic orientation that still characterises much health psychology.

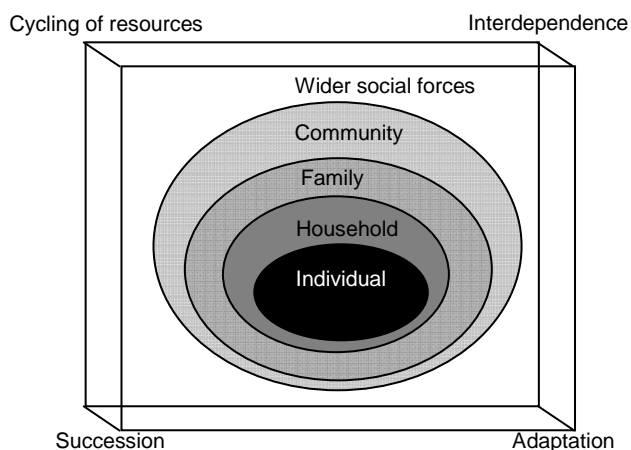
There are many varieties and components of community health psychology. What is of particular relevance to my evolving social psychology of coping is the focus of community health psychology on collective action. This component allows researchers to understand the dynamics of a 'health-enabling community context' and social change (Campbell & Murray, 2004). This is an important value for a social psychology of coping as it not only attempts to enhance our understanding on how people cope, but also allows for explanations and suggestions to how people are able to actively move forward and collectively facilitate coping and resilience.

This may sound overly utopian. However, as Nelson and Prilleltensky (2005) put it, idealistic values allow one to work with a vision of what a good society should be like – and it is this solidarity and drive for social change, recognition of local knowledge systems and social structures and networks that allow for participation and makes a social psychology of coping relevant.

An integral part of community health psychology is the analysis of interfaces between various ecological levels. Considering the complex nature of coping, an ecological framework can aid the analysis and development of a social psychology of coping. Kelly's (1966, 1970) ecological

approach to health (see Figure 2) provides a useful starting point for conceptualising the interaction of individuals and the wider social context in facilitating coping and resilience.

Figure 2: Ecological levels of analysis



Kelly identifies the individual as one of five interdependent levels of analysis (individual, household, family, community and wider social forces), which need to be taken into account in understanding how individuals cope with their daily challenges. This system (as outlined by Figure 2) is governed by four horizontal principles. Firstly, the principle of *interdependence* asserts that changes to one level in the system will impact other parts of the system. An example will be the ripple effect of AIDS from a household level (micro-system) to an individual level, with children resuming caring responsibilities as family members fall ill. Secondly, the principle of *'cycling of resources'* refers to the development, allocation and identification of resources within a system. One clear example of the cycling of resources in Kenya is the mobilisation of grassroots groups who in wake of HIV/AIDS provide invaluable care and support for those with fewer resources. This includes community and church groups, networks and community members assisting in the care and support of young carers. Thirdly is the principle of *adaptation*. This principle suggests that individuals, and the systems they live in, adapt to changes in the eco-system. For example, the AIDS epidemic and the growing number of ailing and ageing guardians has made it acceptable for boys to do household chores, such as cleaning and cooking, ones that were historically unacceptable for boys. Finally is the principle of *succession*. As succession focuses on the historical context of a problem, succession involves a long-term perspective that requires careful planning and consideration of the future. Related to this study, succession could refer to the continued framing of orphaned and caregiving children as passive victims in accordance with dominant conceptions of childhood. Such conceptualisation may prove harmful and not facilitate relevant programming in their support.

Vertically, and related to the principle of interdependence, are an additional four levels of analysis for my ecological framework. These four levels follow the more conventional onion-like structure of layers with the individual at the centre, comprising of the age, sex and orphan status, surrounded by four other layers, including variable factors at a household level, family level, community level and

wider social forces. Such an approach of analysis places the children at the core, but concedes to the primary influences of society through these different ecological layers.

These vertical and horizontal levels of analysis manifest the interchange between the layers. This approach not only helps us to understand the pathogenic or oppressive qualities of human environments and systems, but more importantly allows us to enrich our understanding of how these different levels interact to facilitate local coping strategies and processes that facilitate health-enabling communities and social change.

A focus on human environments and systems is important for two reasons. Firstly, communities serve as the mediators between the different ecological levels of analysis outlined in Figure 2. Local contexts produce their own representations of childhood and resilience. It is through these contexts that young carers negotiate their social lives and identities, ones that allow them to actively participate in matters that concern them (agency). Secondly, there is a generally agreed consensus that collective action increases the likelihood that people will take ownership of the problems they face, a step that will ideally enable people to cope and act in health-enhancing ways.

Many young carers have to cope with the grief of witnessing a parent's slow disintegration, coupled with their responsibilities of palliative care and subsequent death (Martin, 2006). Biomedical and behavioural approaches to support children cope with such grief would focus on the individual through grief-specific therapies (as encouraged by Cluver et al., 2007; Gwandure, 2007; Makaya et al., 2002; Martin, 2006; Mendelsohn, 1997; Sengendo & Nambi, 1997). However, two meta-analyses of such approaches independently reached the conclusion that an individualistic focus is relatively inefficacious. One of the studies even suggests that 38% of the individuals receiving grief treatment got worse (Kato & Mann, 1999; Neimeyer, 2000). Neimeyer (2000) through his review of 23 separate studies of 1600 people experiencing bereavement of loved ones (ranging from spouses, children and parents) found grief counselling and therapy to be modestly beneficial to those traumatically bereaved and ineffective, or harmful, for those experiencing a normal bereavement. In light of the limited success of such models, there is an urgent need for the development of alternative approaches. I hope my evolving social psychology of coping, with emphasis on a community-level of analysis, will contribute to meeting this need.

In the Introduction I defined community as people who are part of an inter-dependent system, and whose actions have effects on each other by virtue of their participation in a joint system. This perspective on communities suggest that human development is always collective and shared with others (Corsaro, 2005). Echoing Corsaro (2005) I believe that the level of analysis for studying children and their life circumstances and transitions must therefore always be that of the collective. For that reason I take 'collective action' to refer to the child in interaction with others within a socio-cultural context acting upon circumstances posed by changing life circumstances in a context of disease and poverty.

Having outlined what orientation (salutogenic), discipline (community health psychology) and framework (ecological) that shall be guiding the thesis, the forthcoming discussion of coping will examine the term and further highlight the need for a social psychological understanding of coping in order to address the gaps in the literature and the aims and objectives of this study.

2.2 Coping and resilience in context

The previous section outlined how a salutogenic orientation can inspire us to focus on the processes that allow any children to rise above disadvantage, a phenomenon under-researched in disparate cultural contexts as found in SSA (Hunter, 2001; Luthar & Zelazo, 2003). In my effort to develop a social psychology of coping, it is useful to briefly locate my conceptualisation within existing literature on coping and resilience. One cannot talk about coping without mentioning resilience and vice versa. Resilience is the outcome of successful coping, so children showing resilience have drawn on successful coping strategies. This section begins with an account of resilience research, looking at some of the theorised pathways (coping strategies) to resilience and how they can contribute to a social psychology of coping. This is followed by a contextualisation of coping within the relevant literature, which helps me outline the way in which I intend to use and conceptualise coping.

2.2.1 The 'ordinary magic' of children and conceptualisations of resilience

Fascinated by his observations of children at risk for psychopathology developing well, Garmezy was the first academic to suggest that children are more competent and resilient than researchers within child psychopathology and development had previously thought (cf. Garmezy, Masten, & Tellegen, 1984; Garmezy & Rutter, 1983). Masten (2001) argues that over 50% of children facing difficult circumstances and multiple risks appear to adapt well to their adverse circumstances through coping and resilience, with no need for assistance. Masten (2001) refers to children's unique adaptive behaviour as the 'ordinary magic'. But what happens to the remaining children who do not appear to adapt that well to their circumstances? Many probably struggle quietly, but adapt to their circumstances and survive/cope, and some may suffer from more severe psychosocial distress and would benefit from some kind of professional counselling.

To help children in difficult circumstances adapt well to their circumstances there is a need to understand the 'magic' that surrounds the children showing resilience. The need to understand this magic has sparked a number of studies and conceptualisations of resilience. According to Luthar and colleagues (2000; 2003) early writings on resilience spoke about invulnerable children (e.g. Rutter, 1979), children who did well despite multiple risks, suggesting that risks are static and resilience an individual characteristic that some children have and others do not.

However, recent developments within resilience research suggest that resilience is a result of multiple and contextual and social factors. Most definitions on resilience refer to the presence of 'risk' and the ability to 'do ok' (Bonanno, 2004; Luthar & Cicchetti, 2000; Masten & Coatsworth,

1998; Masten & Powell, 2003). Although they broadly agree on the definition of the term, the pathways towards resilience are conceptualised differently.

Both Garmezy and Masten place great emphasis on competence (Garmezy, 1987; Masten & Coatsworth, 1998). They use competence to refer to a pattern of effective adaptation in an environment, looking both at successes of tasks expected of a person of the given age and gender in their culture and more specifically on domains of achievement (Masten & Coatsworth, 1998). An example of these tasks and domains would be conduct in an educational setting. Children are generally expected to learn and follow the rules of a class room and develop peer relationships. Another domain frequently used to measure competence is that of academic achievement. Masten and Coatsworth (1998) have therefore identified some specific characteristics of resilient children and adolescents in difficult circumstances that are placed against developmental tasks appropriate to their context - such as school adjustment and academic achievement.

Rutter (1993) concentrates on the interplay between risk and protective factors. Using immunisation as a metaphor, where exposure to a pathogen is controlled, he suggests that resilience results from having experienced a risk at a time and in a way that allows the individual to cope successfully with similar risks in the future. Rutter (1985) asserts that certain prior adverse experiences may protect for future shocks and good experiences may counteract negative experiences. This is not dissimilar to Gilligan's (2000) study that found positive experiences in school and in children's spare time to be protective in adverse experiences. To this end, Gilligan (2000:40) argues that "the naturally occurring opportunities in daily living may ultimately prove more therapeutic than ones which are specially contrived or engineered", an argument I seek to develop from a different position.

Prilleltensky et al. (2001), like many other academics engaged with resilience research, draw on an ecological framework. Whilst most resilience research is framed at the level of the family and the child, looking at traits such as intelligence and social skills, Prilleltensky et al. (2001) focus on the role of power and control within an ecological framework. They argue that participation and self-determination gives us a voice and choice to define our sense of agency, promoting self-efficacy which serves as a protective factor in the face of adversity, a principle that is core to my evolving social psychology of coping and which I will return to in Section 2.4.3.

Although the majority of conceptualisations listed so far acknowledge the impact of the environment in facilitating resilience, they remain focused on the psychological characteristics of the individual and pay little or no attention to wider macro-social determinants such as influences by social discourses and representations (e.g. of childhood and mental health). In response to this gap, Michael Ungar (2004) has developed a constructionist notion of resilience, which this study aligns itself to. It is an understanding of resilience that reflects the ideas of Foucault, Summerfield and Escobar, and which suggests that those with the most power to control social discourses also influence our definition of what health and illness is (cf. Gergen, 1991; 1994).

Michael Ungar (2004) argues that studies that depict resilience as an absolute (psychological) measure of health despite adversity, are informed by a discourse that assumes that individuals showing resilience display certain capacities and characteristics that are unexpected in the face of the risks they face and the consequences this might have for the future. To avoid feeding this pathogenic discourse, Ungar (2004) argues that we must be open to contextual understandings and knowledge of health, coping and resilience rather than using the universally accepted definition of resilience and coping. He suggests that one way of doing so, is to view resilience as the outcome of negotiations between individuals and their environment for the resources and representations that promote health and well-being despite conditions collectively perceived as adverse (ibid.). Following a series of resilience studies cross-culturally, Ungar (2008:225) found that “in the context of exposure to significant adversity, whether psychological, environmental, or both, resilience is both the capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of well-being, and a condition of the individual’s family, community and culture to provide these health resources and experiences in culturally meaningful ways.” This definition of resilience is particularly useful for this thesis as it highlights the necessity to shift attention from the individual to the individual-community interface, as well as highlighting the active participation of children and their communities in the coping process. Panter-Brick (2002) has observed and drawn on similar understandings of resilience in her work with street children. She found resilience to be an outcome of children’s agency. This study seeks to explore if this is the case with young carers in Kenya and examine the strategies the children use to cope.

In summary, resilience researchers have, by and large, had two foci. The first is Western-based and focuses on individual/psychological and relational factors that draw on universal understandings of health and functioning in relation to developmental tasks (e.g. Garnezy et al., 1984; Luthar et al., 2000; Rutter, 1987). The second focus considers community and cultural factors that contribute to a local definition of resilience (Ungar, 2004, 2008). The varied conceptualisations of resilience open up the possibility of seeing resilience as facilitated by numerous and diverse coping strategies. The next section will define coping as it will be used in this study.

2.2.2 Coping contextualised

Coping is a widely used term that has been measured and conceptualised differently over the past 60 years. However, most conceptualisations of coping focus on the psychological attributes (e.g. cognitive, affective) of the individual copier. Lazarus (1993; 1966) for example, although he facilitated the move of ‘coping’ away from being a personal trait and cognitive style (rational decision making) to be a process influenced by a context and environment, is still focused on the individual’s emotional encounter with stress. His analysis includes motivation and problem-focused coping, suggesting that thoughts and instrumental (rational) behaviours help manage stress (Lazarus & Folkman, 1987). These problem-focused thoughts have been explored and promoted the study of the impact of positive reappraisal (cognitive) and of positive life events (affective) on coping (Folkman & Moskowitz, 2000). This is not dissimilar to Lois Murphy’s (1962)

conceptualisation of coping through his use of the term 'Mastery', used to describe the ability of an individual to deal with the environment and still find pleasure, self-pride and esteem.

Even researchers in the social constructionist frame focus on coping in terms of the meaning that the coper constructs for his or her experience, with inadequate attention to the way in which coping is a function of the individual-society relationship rather than a property of individuals. Lipowski (1970) believes that the subjective meaning of a stressor (he uses the example of illness) plays an important role in how individuals are able to cope with adversity. In a similar vein, Antonovsky (1987) argues that the level of sense of coherence individuals are able to construct despite adverse circumstances facilitate successful coping.

Whilst each of these dimensions of coping is vitally important, such understandings of coping neglect the individual-society interface. Counter to these cognitive and individual understandings of coping, the aim of this thesis is to focus on community-level features of coping, and in particular to examine the way in which coping is shaped by the extent to which the children are able to participate in the community in which they are living. My understanding of a social psychology of coping is therefore the process through which children and community members actively negotiate and provide support,

A social psychological understanding of coping is important for two reasons: Firstly, there is an emerging recognition of the agency of people in developing countries – they are not merely seen as passive victims and recipients of aid, but are increasingly seen as social actors pursuing rational strategies (Abebe & Kjærholt, 2009; Porter, 1996; Ungar, 2008). Secondly, there is a growing consensus that people belong to a household, a community, a social network and therefore health-enabling action needs to be understood in relation to a social context (Campbell, 2001, 2003). Despite these positive developments and understandings, there are scholars who pertain to claim that “the euphoria over coping strategies obscures the real experience and suffering of individuals, households and communities” (Rugalema, 2000:540). However, with the current one-sided representation of OVC as passive victims, there should be no danger of coping studies blurring the difficult circumstances lived by many OVC.

Contrary to the psychological literature, most of the existing coping research in Africa looks at coping at a household level and often in relation to famine (Adams, Cekan, & Sauerborn, 1998; Watts, 1983) and disease (Ansell & Van Blerk, 2004; Evans, 2005; Sauerborn, Adams, & Hien, 1996). Only three papers have been written on processes that can facilitate the coping of OVC in Africa (Daniel et al., 2007; Fjermestad et al., 2008; van Dijk, 2008). Whilst a household level of analysis has got many benefits to uncover certain coping strategies, such studies should be complimented by studies looking at social structures at a community level that impact on coping. The coping literature on responses to famine tends to define coping as an array of short-term strategies adopted in response to crisis (Adams et al., 1998; Davies, 1993). Questions have been raised on the transferability of the concept of coping in a famine context to that of HIV/AIDS (Rugalema, 2000). My particular concern with a definition focusing on crisis situations is the danger

of neglecting the long-term strategies that young carers must adopt as their caring responsibilities extend beyond a temporary crisis stage and become more or less permanent.

Against the limitations of existing conceptualisations of coping, the next section explores and presents a framework and conceptual tool that can be used for policy and practice to understand the implications of a social psychology of coping.

2.3 Orphan competent communities

My aim of developing a social psychology of coping is to develop an understanding of how we can promote and enhance community contexts that can facilitate the coping of orphaned and caregiving children. I refer to such a context as an orphan competent community (OCC). To do this, I will in this section elaborate on some of the social psychological resources that have been identified to hinder or enable children and community members to negotiate and provide support.

I draw on Campbell et al.'s (2007; in press) work on 'AIDS Competent Communities' (ACC). They define ACC as a community where people are most likely to work collaboratively to tackle the challenges of HIV/AIDS (including avoiding infection, caring for the sick, and accessing support and treatment). With their community-level focus and identification of social psychological resources (dimensions of an ACC) that can enable or hinder support, this is a useful starting point for developing OCC. However, in the case of OVC, I need to expand this framework through making more specific reference to the material and social resources needed to support OVC, and further develop the concrete strategies required to strengthen OCC. I define an OCC as a context in which orphaned and caregiving children and their fostering households are best able to successfully negotiate and access support from their social environments (including extended family, friends, neighbours, self-help and volunteer groups, church groups, schools, NGO and government welfare services). As a starting point I have used the same dimensions of an ACC, but in the process of reworking the six dimensions of an ACC into those relevant to an OCC, I combined local strengths and agency into one broader category, truncating the six social psychological dimensions outlined by Campbell et al. (2007; in press) into five. The characteristics of an OCC are:

1. Appropriate knowledge and life skills
2. Awareness of local strengths and agency
3. Economic and political ability to participate
4. Solidarity and partnerships
5. Supportive social spaces

As my definition of an OCC, as well as the five dimensions listed above, will depend on "the structure of relations between actors and others" (Coleman, 1988:98), also referred to as social capital, I want to intergrate Woolcock's policy framework (Woolcock, 1998, 2001; Woolcock & Narayan, 2000) in my explanation of the five dimensions of an OCC. This framework constitutes four types of social capital: (i) social capital within local communities (bonding); (ii) social capital

between local communities and groups with external and more extensive social connections to civil society (bridging); (iii) social capital between civil society and macro-level institutions (bridging); and (iv) social capital within corporate sector institutions (bonding). Woolcock (1998) argues that all four types of social capital must be present for optimal development outcomes. However, echoing the focus of this study, I will mainly integrate the first two types of social capital, namely intra-community ties and extra-community networks.

In combining Campbell's social psychological resources, Woolcock's framework of social capital and my empirical findings, I hope to provide a convincing and actionable tool that can be used for the analysis of policy and practice of interventions that facilitate coping. There is increasing evidence that social capital can be intentionally generated, particularly through the use of group-based microfinance initiatives (Dowla, 2006; Mladovsky & Mossialos, 2008; Pronyk et al., 2008; Skovdal et al., 2008), which is relevant to the intervention used in this study (see Section 2.4.2).

The five dimensions highlighted above are core to my evolving social psychology of coping as they bring forward the content and processes, mediated by the individual-community interface, which might, or might not, facilitate the coping of young carers. An explanation of the five proposed dimensions will now follow, however, the final conceptualisation of the tool, which include one more dimension, will follow in the concluding chapter of this thesis.

2.3.1 Appropriate knowledge and life skills

In an OCC, children and community members have knowledge about practices that can help them cope and the skills to action these practices. Through history, culture and social representations, people will through communication and practice, construct a shared view of the world and what skills are required to survive and cope with adversity in their context (Jovchelovitch, 2007). Related to intra-community ties, some life skills and knowledge reflect the expectations between individuals, constituting norms and effective solutions to undesirable circumstances (Coleman, 1988). As a result, adults may encourage children to participate in activities that give them the knowledge and skills to cope with adversity. This will not only allow the children to provide the best possible care for their guardians, but also give the children a chance to cope with poverty and adversity. Having said that, the intra-community ties that encourage children to acquire appropriate knowledge and life skills can also constitute the negative effect of social capital that Woolcock (2001) refers to, as children and adults may be exploited for their skills, presenting enormous claims to their commitment, cutting them off from other opportunities (e.g. school).

Numerous studies point towards the importance of children gaining appropriate knowledge and life skills to survive (Abebe & Kjørholt, 2009; Fortes, 1938; Katz, 1986; Raum, 1940). Cindi Katz (1991), following a year of geographical field research in southern Sudan, found children's participation and knowledge on farming and the environment to be important for the survival of agricultural production. Porter (1996), through a study of the Pare people in Tanzania, found girls and boys under the age of seven to be learning about work and the environment by observing and imitating

others. She found Pare children to be accompanying adults to the fields with the aim of learning to distinguish between weeds and crops, wild plants and fruits and species of birds and performed small tasks that increased with skills, knowledge and age (ibid.). Porter (1996) also found gender to be shaping the development and acquisition of knowledge gained through processes of work and play as they accompany older boys and girls in gendered roles.

There are clearly many different levels of knowledge and life skills. Knowledge would also constitute being aware of how knowledge is used, exploitative or not, within a community context. Similarly, life skills would not only constitute people's ability to do work related activities, but also the skills to facilitate collective action and social change. A social psychology of coping takes into consideration the role of local knowledge and skills in coping with adversity.

2.3.2 Awareness of local strengths and agency

To make use of their knowledge and skills, it is crucial for an OCC to be aware of and have confidence in their local strengths as well as having the agency to mobilise these strengths. One of the aspects of an OCC relates to people's abilities to identify existing individual and collective coping strategies and develop confidence in those strengths. Campbell and colleagues (2007) speak of this social psychological resource in relation to how confidence in individual and groups strengths can make an effective contribution tackling the impact of HIV/AIDS, and their sense of agency to action these strengths.

At an individual level this might involve having confidence in the access of support from community members and neighbours in times of hardship. This require what Coleman (1988) refers to a trustworthiness of structures and is integral to bonding social capital. A caregiving child might feel that helping an ailing relative or neighbour will pay off, as once they are feeling better they will support the child. If that is one of the rationales for caring, there must be trust in the reciprocity of support. Likewise there must be confidence in what the children can achieve. Let it be their role to carry out activities in support of a bedridden person, or their participation in the labour force as part of a system of reciprocal exchanges (Abebe & Kjørholt, 2009; Abebe & Skovdal, in press). The growing emphasis on OVC as 'innocent' and 'vulnerable' victims, may limit their confidence and self-efficacy. A social psychology of coping takes into consideration the social representations and identities that may, or may not, be imposed onto communities and affect their confidence.

In order to enhance OCC, service providers and researchers must also have confidence in the strengths and agency of community members. This will encourage a shift away from victimological representations that undermine, and at worst inhibit, local strengths and agency to overcome vicissitudes. Confidence in strengths and agency can be encouraged both by intra- and extra-community ties. For example, if community members have confidence in their strengths and agency, this is more likely to enable them co-ordinate activities for mutual benefit (Putnam, 2000), from which they will gain further confidence from. Confidence in their strengths can also be

facilitated through participatory interventions with service providers (Skovdal et al., 2008). The next social psychological resource will explain this in further detail.

2.3.3 Economic and political ability to participate in community life

A third dimension of OCC is the ability of community members to participate in community life free from economic and political constraints. As the participation and collective action of many rural African communities is constrained by their lack of economic resources, or power (e.g. marginalised groups of people), there is a role to play for service providers to facilitate power and control as well as making economic resources available. Communities that accept the need for extra-community ties, as well as are supported by external partners, are more likely to have access to the political and economic resources that enable them to action responses that address the needs of OVC (Woolcock & Narayan, 2000).

To cope with adverse circumstances, community members need to have the power and control to participate meaningfully in community life and have access to valued resources (Campbell & Jovchelovitch, 2000). For children, such resources are even more difficult to come by. Their lack of economic and political power leaves them with little control over important aspects of their lives and are thus less likely to take control over their well-being. In this thesis, drawing on the principles of Paulo Freire (1996, 2005), I bring together marginalised children and engage them in decision making processes that affect their lives, promoting power and control. However, power and control in poor resource settings is not enough. Prilleltensky and colleagues (2001) have noted that alongside the political ability to participate, community groups should also be given the economic resources to meet their goals, stressing the need to involve service providers. This reflects Woolcock's notion of bridging social capital and the importance of extra-community ties. Communities and grassroot groups can benefit from building relationships with more powerful and resourceful CBOs, NGOs and government departments. This is supported by Evans (1996) who has found that norms and networks of civic engagement can be promoted by service providers and used for developmental ends.

However, many communities do not have the confidence to build relationships with more powerful organisations that can bridge them with much needed resources, suggesting the need for service providers to actively seek and mobilise grassroot groups to support their local responses. In this process it is imperative that service providers recognise what Moser (1998) refer to as a community's 'portfolio of assets', which includes the role of children, local knowledge and community members' abilities to provide care and support. Recognition of local assets by service providers is crucial for a fruitful relationship and partnership between service providers and local communities.

2.3.4 Solidarity and partnerships

Another important social psychological resource that characterises an OCC is that of solidarity. Solidarity is based on generalised norms of trust and reciprocal help and support between community members. This can lead to partnerships between individuals who set up community groups in aid of OVC, as well as partnerships between community groups. This sense of solidarity and partnership building amongst local community members reflect Putnam's (1993) definition of social capital.

A social psychology of coping helps us understand why individuals who are part of a community with high levels of solidarity and a range of locally community organisations and grassroot groups cope better. This is because people in communities with high levels of solidarity, trust and supportive relationships, are more likely to work collectively and achieve goals of mutual interest (for example through the care and support of people with AIDS and their children). Communities characterised by solidarity are therefore more likely to show empathy and be supportive of children's circumstances (Morrow, 1999a).

Partnerships between grassroot groups within a community are important for the coping of children and their communities for two reasons. Firstly, collaboration and deliverable relationships with organisations within the community, allows the community to co-ordinate responses in times of hardship. Secondly, partnerships facilitate a sharing and building of ideas and resources and help co-ordinate local responses that help caregivers cope. Communities that fail to network and build partnerships may miss out on support from government departments, aid agencies and the private sector (ibid.). Much has been written about the usefulness of partnerships in improving well-being and a literature review on the impact of alliances and partnerships by Gillies (1998) found 'partnerships' and 'alliances' to be important signifiers of a health-enabling context.

2.3.5 Supportive social spaces

The fifth and final social psychological resource, or criterion, of an OCC is that of supportive social spaces. What children need above anything else is safe and support social spaces in which all community members examine the ways in which support for OVC is best achieved. Community members need supportive and sympathetic social spaces in which they can collectively discuss their anxieties about the growing number of orphans and brainstorm ways and the type of support the children require. In supportive social spaces, people can also renegotiate the individual and social norms that hinder or facilitate support to OVC. Due to the multiple interests and identities of people, the engagement of community members in building supportive social spaces differ significantly. Supportive social spaces are therefore often instigated by community organisations and church groups who work for a common course. Their engagement can of course have a trickle effect and influence the wider social community.

Such an effect has been observed in the Bondo district of Kenya where the extended family is increasingly stretched by the growing number of OVC. Local community organisations and new

social support networks and initiatives have sprung up in response to the increasing number of orphaned children and is increasingly accepted as the norm in familial care (Nyambedha & Aagaard-Hansen, 2007).

The church is one of the most well-established social networks, and in settings with limited access to health and welfare support and services, serves as a vital community resource and social space. Many church groups provide spiritual and practical support to children affected AIDS. However, at the same time, churches play a key role in perpetuating stigma against people living with HIV/AIDS which can have a dramatically negative impact on their well-being (Campbell, Foulis, Maimane, & Sibiya, 2005; Hartwig, Kissioki, & Hartwig, 2006), exemplifying the potential negative effects of social capital.

Building on solidarity, supportive social spaces and relationships play a vital role in sustaining health and well-being (Campbell, 2001; Cattell, 2001; Cohen, Gordon, & Gottlieb, 2000). This is particularly evident in Africa where, for example, the clan system has always played an important role in helping individuals and communities cope with difficult circumstances (Ankrah, 1993; Serra, 2009). Extended family members, grandmothers (Nyambedha et al., 2003b) and children (Ansell & Van Blerk, 2004; Skovdal, in press), all whom contribute to the creation of supportive social spaces in helping fellow family and community members cope with hardship.

Numerous tools have been developed to facilitate supportive social spaces, again highlighting the role of extra-community ties. These tools can be used to sensitise and mobilise communities on the issues affecting OVC. Some of the more established tools include Stepping Stones (Welbourn, 1995), Community Conversations (UNDP, 2004) and Participatory Learning and Action tools (Rifkin & Pridmore, 2001). These tools can help community members and children engage in dialogues that refine and develop health-enabling social identities as well as provide them with an awareness of their life challenges and how best to respond to these.

2.3.6 Summary

So far in this chapter, I have established the orientation (salutogenic) and the discipline (community health psychology) that guide my conceptualisation of a social psychology of coping. From community health psychology I adopted an ecological framework to begin to map out those dimensions of the social environment that frame the experiences of young carers (see Section 2.1.4) as this is likely to encapsulate the nuanced and complex ecological levels that interact with each other. The experiences and coping strategies by young carers are likely to be a result of numerous factors at different levels of analysis. Figure 3 highlights the different ecological levels of analysis that I have identified, partly through a review of the literature and partly from early observations of my data (discussed later), to impact on coping. The primary level of analysis for this thesis is the white circle of Figure 3, comprising of the community, which is the interface between the social and the individual and also the location of my, so far, five-point conceptualisation of an OCC (these are starred*).

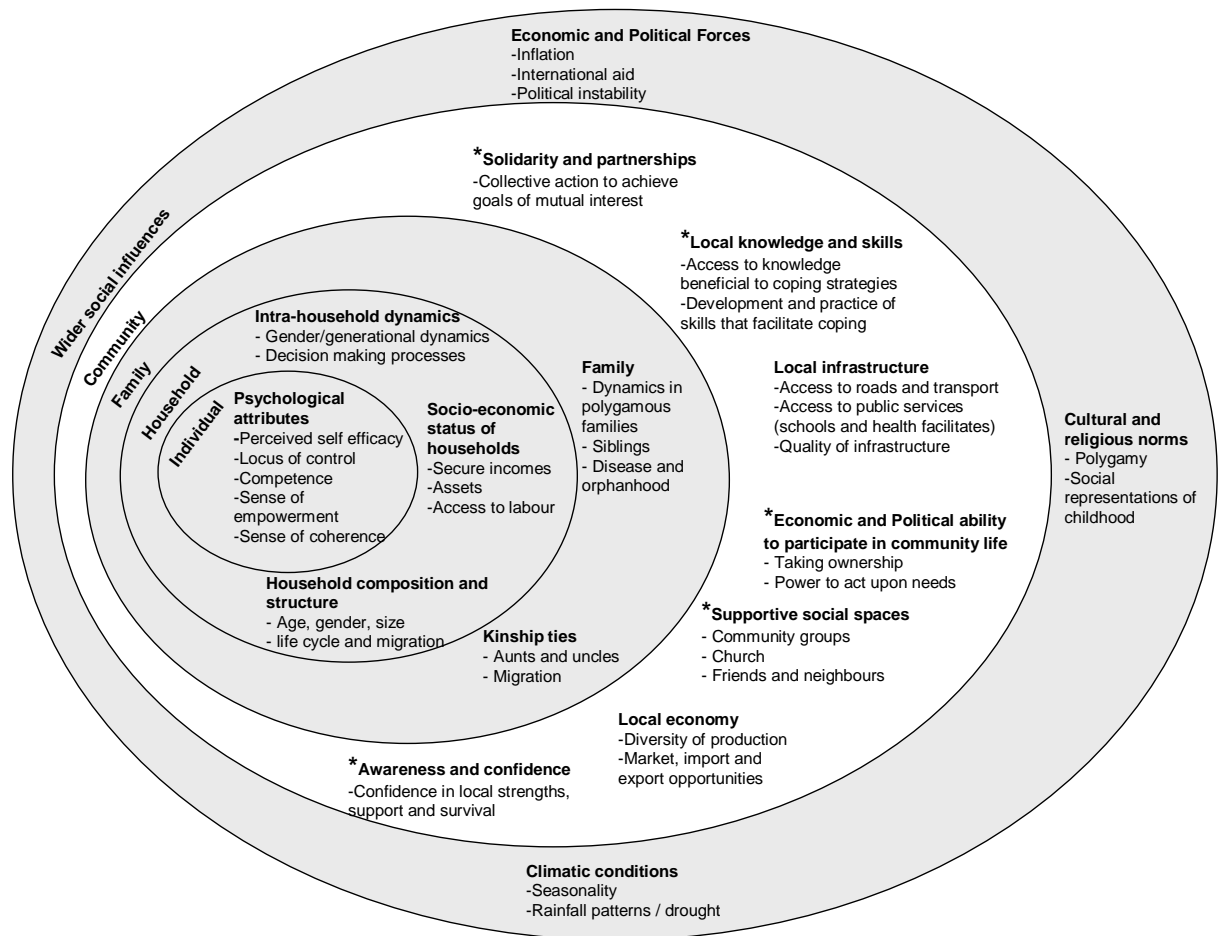


Figure 3: The context of an orphan competent community

Whilst all of these levels play an important role in facilitating coping, it is the community-level of analysis that is of particular interest to this study. I will argue that the five-point conceptualisation of OCC described in the previous subsections of this chapter and outlined with stars in Figure 3, provide background to how a social psychology of coping can be understood and conceptualised, albeit in the context of orphaned and caregiving children. Each of the five factors making up an OCC is believed to promote community cohesion and facilitate the making of a context that allow children to successfully cope with adversity as they negotiate and access support from their social environment. Content and an additional social psychological resource will be added to my evolving conceptualisation of OCC in the concluding chapter. The forthcoming section will examine how an OCC can be made actionable by facilitating these five social psychological resources.

2.4 Promoting coping and resilience through participation

In my effort to conceptualise coping as a social psychological process, the previous section outlined five social psychological resources, at a community level, that may, or may not, facilitate coping processes. As these social psychological resources are negotiated within the communities through participation, there is a need to look at the role of participation in promoting coping and resilience.

A good starting point is to draw on a conceptual framework developed by Prilleltensky and colleagues (2001). As mentioned earlier in this chapter, they identified power and control to be key instruments in the promotion of resilience (Prilleltensky et al., 2001). In their analysis of power and control in children's lives, they conclude that to promote coping and resilience among children, policies and programmes must address three facets of power: (i) access to valued resources, (ii) participation and self-determination, and (iii) competence and self-efficacy. As Prilleltensky's pathways to resilience and the pathways that I have identified toward coping (ie. my five-point conceptualisation of OCC) point towards the importance of participation, I begin this section by exploring the relevance of community participation and provide some background to participatory approaches in development. In my effort to conceptualise an actual intervention that can promote an OCC, I then examine the potential of a CCCT initiative in integrating and facilitating the participatory processes that can promote the five social psychological resources that make up an OCC. I conclude this section by presenting a conceptual model that shows the potential pathways between the CCCT intervention, OCC and coping.

2.4.1 Community participation and development

As a social psychologist I believe that community and participation are two intrinsically connected terms that must be discussed in relation to each other (Campbell & Jovchelovitch, 2000). This is because the social psychological resources that connect or divide a community are enacted through people's participation in community life. Community members therefore have an impact on the health and well-being of themselves and others by virtue of their participation in community life (ibid.). This may suggest that coping and resilience is also a result of the kind of participation that takes place within a community. Whilst some people may already engage in the kind of participation that enhances children's coping and resilience (this thesis will bring forward what this participation entail), others may not. To increase the number of people within a community who engage in activities that promote coping, service providers may enter a community and facilitate and promote the kind of participation that facilitate each, or some, of the five dimensions that characterise OCC. To do this, we need to identify a participatory intervention, which can promote all five social psychological resources.

A core theme throughout my thesis has been the idea that local representations and way of life are important contributors if we want to develop relevant and successful interventions (Brokensha, Warren, & Werner, 1980; Campbell, 2003). To draw on local representations and knowledge, service providers therefore have to engage and involve community members in the process. Whilst there are different levels of participation (Arnstein, 1969), one method that encourages the participation and involvement of community members in the decision making processes is the PLA cycle (see Figure 4) as described by Rifkin and Pridmore (2001). PLA is about generating information for planning and action, materialised through a step-by-step process or systematic learning process. To achieve this, facilitators work through dialogue with community members, using PLA techniques, to assist them in developing action plans (ibid.). These action plans show how the resources available within a community (e.g. time, people, money) can be made of good

use to achieve collectively identified goals, aims and objectives. Although facilitated by an external change agent, this kind of planning can be empowering and promote the kind of participation and resources that I have identified in my five-point conceptualisation of OCC.

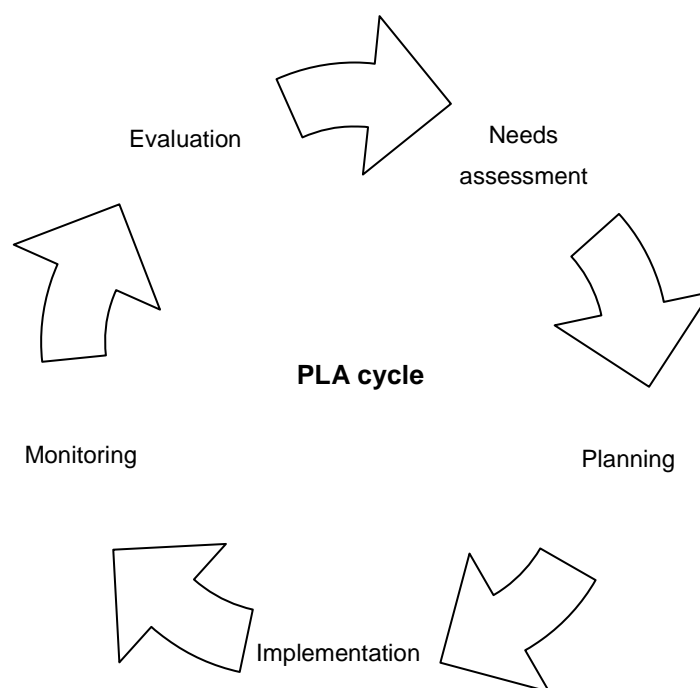


Figure 4: The planning cycle (Rifkin and Pridmore, 2001)

Several theories and disciplines have contributed to our understandings of the PLA cycle. Freire's (1996, 2005) activist participatory approach sought to enhance the awareness and confidence of people, so they would be empowered to take action. To do this, Freire argues that development practitioners must enter into dialogue, as equals, with community members. His recognition that poor people are resourceful and capable, and with facilitation from outside can be empowered, is very useful. However, as Freire mainly refers to the political action of marginalised groups, this arguably limits his contribution to PLA by undermining the need for economic resources to reach their goals. Nevertheless, these principles were adopted by Lewin (1948) who through participatory action research (PAR), conceptualised Freire's principles for a broader audience, with academics from various disciplines drawing on the concept. Another educationalist who draws on the idea that reflection leads to action is Kolb (1984) who through his experiential learning cycle has influenced much teaching in various learning institutions (Seaman, 2007). Experiential learning is commonly defined as "the change in an individual that results from reflection on a direct experience and results in new abstractions and applications" (Itin, 1999:93).

Almost at the same time as Freire and Kolb developed their theories, Robert Chambers (1983, 1992, 1997) drew on constructivist perspectives and experiential learning to develop rapid rural appraisals (RRA) in reaction to the traditional, tedious and ineffective questionnaire surveys that were developed to assess the needs and circumstances of the poor. By asking 'whose reality

counts', Chambers encouraged outsiders to gain insight and information from rural people and their conditions, by drawing on their participation and knowledge.

Although such constructivist perspectives are influencing much teaching and learning of educational institutions (Fry, Ketteridge, & Marshall, 2002; Ramsden, 1992) and development programmes in the majority world (Cornwall, 1996; Skovdal et al., 2008), including the project reported on in this thesis, they have received much critique. Critics suggest that experiential and reflective learning models offer a narrow and mechanistic conception of learning and ignore the ways perceptions and actions are culturally determined (Fenwick, 2003; Seaman, 2007). In a similar vein, Michelson (1996) suggests that experimental and reflective learning ignores the possibility that all knowledge is constructed within power-laden social processes, that experience and knowledge are mutually determined, and that experience itself is knowledge-driven and cannot be known outside socially available meanings. These critiques do present some limitations to the implementation of PLA and require facilitators to be fully aware of such processes. If, for example, a facilitator entered a community thinking orphanhood is a problem and spoke of orphaned children as vulnerable victims, this may well influence how community members proceed with their reflection and actions. Another example of how power and knowledge can influence the outcome of the process, would be if the facilitator, in describing the PLA process, gives examples of certain actions. One danger of such examples, as I have observed in Kenya, is that they may be perceived by community members as instructions to what their actions should be (Skovdal, 2006).

Nevertheless, the aim of the PLA process used in this study (see Figure 4) is to sensitise the community to issues affecting OVC and hopefully facilitate the kind of participation that promotes a sense of solidarity and supportive social spaces. As community members analyse the difficulties faced by OVC and explore ways in which they cope, an awareness of the kind of knowledge and skills necessary to strengthen their coping will become clear, as well as an awareness of community strengths and limitations in improving the coping of OVC. This process of reflection and awareness is important and this on its own may make it easier for children to negotiate support as they participate in community life. However, in a resource poor context, an actionable OCC will not assume that increased awareness by the person or group of people who have been facilitated to reflect upon the circumstances of OVC, will necessarily lead to action. The argument is, it is not enough to raise awareness and empower marginalised people to take action, they must also be provided with the economic resources to do so.

To further illustrate how a participatory programme can promote the five social psychological resources that characterise an OCC (and effectively the coping of children), I will in the forthcoming subsections give detail to the process of a CCCT initiative and subsequently highlight its potential pathways toward coping and resilience.

2.4.2 Community-based capital cash transfers

In the introduction of this thesis I briefly mentioned CCCT as an alternative (from household-based cash transfers) approach to support OVC. I gave brief detail to how CCCT had been implemented in Kenya across 13 districts. Drawing on my involvement and observations from the evaluation of this programme, I will in this subsection give more detail to its implementation and try and forge links between participation, the CCCT implementation process and coping, with the aim of outlining the potential (albeit theoretical) of CCCT initiatives in building OCC.

The CCCT process implemented in Kenya by DANIDA and the DGSS followed many of the same steps outlined in Figure 4 earlier. However, in addition to facilitating action through reflection and awareness, core to CCCT is the transfer of cash into a community initiative fund that will help materialise some of the actions and goals identified by a community. After the communities had reflected upon the needs and circumstances of OVC, they got involved in the planning and implementation of activities, made possible by the cash transfer. As the name implies, CCCT targets communities. However, the communities can either be of shared circumstances or geographical communities. In supporting young carers, for example, CCCT could either work directly with the children (being a community of shared circumstances) or indirectly by working with all stakeholders within a geographical community to support this group of children. Whilst the CCCT programmes I have previously been involved with targeted orphaned children through all stakeholders within a geographical community, this programme, in attempt to document and bring forward the agency of children, targets young carers (still within a geographical area) directly.

The overall aim of CCCT is to mobilise and sensitise communities to be supportive of a marginalised group and strengthen existing coping strategies. A more detailed outline of how CCCT can potentially mediate coping at different ecological contexts will be provided in Section 2.4.3. CCCT type interventions are not new and resemble group-based microenterprises (Woolcock, 2001). They are often facilitated by outside agencies in poor communities as a way of promoting health and well-being via community participation. Figure 5 depicts five key steps in the implementation of a CCCT programme. However, before any of these steps can commence the funding agency must identify and mobilise a community. The community must democratically elect a project management committee (PMC), who will be trained on book keeping and project management skills. In partnership with the funding agency, the PMC facilitates a needs assessment and survey of the circumstances of, for example, OVC. This assessment uses various PLA techniques to highlight the community's strengths, resources and needs. Following a reflection of their observations, community members will be in a good position to develop an action plan that reflects not only their needs, but actively draws on local resources and possibilities. The community develops, in dialogue with the funding agency, an action plan. Once the action plan is finalised, training sessions specific to the project are arranged. An example of project specific training might for example be training on goat keeping and combating goat's diseases, in the case of a project where goats were given to children. Funds are subsequently transferred to a designated community bank account, enabling the PMC to commence the implementation of their action plan, with the community playing an active role in monitoring and evaluating the project's progress (see Skovdal

et al., 2008 for a case study of CCCT). This approach is specifically designed to promote community ownership of the project, as well as drawing on and building local skills and confidence to make any necessary changes to the project plan as it evolves, and possibly to repeat the project cycle if this seems appropriate (Skovdal et al., 2008; Tomkins, Mwasijaji, Mbale, & Skovdal, 2008).

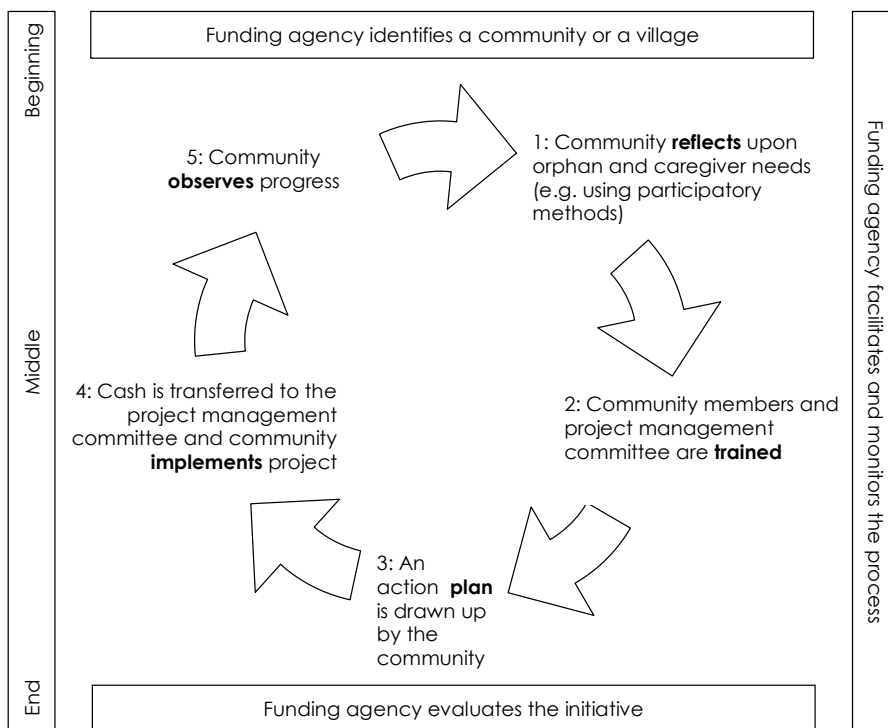


Figure 5: CCCT process in Kenya (Skovdal et al., 2008)

Experiences from Kenya suggest that this process does have the potential to build OCC, giving community members the confidence and resources (perhaps incentive) to provide care and support for OVC (Skovdal et al., 2008). In the programme orphaned children expressed increases in care and support, which is reflected through their improved school attendance and performance (Tomkins et al., 2008). Nevertheless, much more research needs to be carried out on CCCT to make any claims of its ability to build OCC. To facilitate future research, the next subsection will theorise and bring forward some of the pathways through which the CCCT process can potentially facilitate coping and resilience.

2.4.3 Pathways toward coping and resilience

Against the background presented above, I now turn to highlight the potential of CCCT in building OCC that better facilitate coping and resilience of OVC. Drawing on a model produced by Prilleltensky et al. (2001), Table 4 outlines some of the qualities of the CCCT process that are likely to facilitate the development of OCC, mediated by ecological contexts. In doing so I argue that the five steps presented in Figure 5 have the potential to facilitate the kind of community-level participation that facilitate the five social psychological resources that characterise OCC. Table 4 also identifies some of the likely indicators of an OCC that promote coping and resilience. This

model is far from comprehensive and only indicates a minority of the possible pathways towards successful coping and resilience.

Table 4: A model showing the process through which CCCT has the potential to promote OCC, coping and resilience

Key steps in CCCT process	Resulting qualities of CCCT that enable and facilitate the building of OCC.	Indicators of an OCC that promote coping and resilience
A community is mobilised. A project management committee is democratically elected. Through participatory exercises, the community reflects upon their circumstances, strengths and needs.	Macro level – Governments and funding agencies provide communities with a voice and choice in interventions that affect them. Community level – The community accepts common characteristics, problems and the circumstances that impact of children affected by AIDS. Family/Household level – Household members give the participating community members time, space and support to be involved in the process.	Communities actively use their voice and exercise agency through participating in civic affairs. Community members take ownership and responsibility of the challenge of providing adequate care and support to children affected by AIDS. Children participate in household matters. Their views are heard and taken seriously.
The wider community is trained in issues that affect the target community e.g. orphan care and support; existing services within the context. The target community is trained in project management skills including book keeping and proposal writing. The target community later receives training on issues reflected in their action plans.	Macro level – Educated facilitators transfer skills and knowledge that will act as catalysts for change. Community level – Appropriate knowledge and life skills are shared amongst community members, strengthening solidarity and supportive social spaces Family/Household level – Fostering household members develop deeper understandings of the circumstances that impact on the well-being of their foster child.	Social, educational and community services are available and accessible to community members The wider community is supportive and the target community has gained useful knowledge to act upon their circumstances. Household members are supportive and loving to children.
Following reflection and training, the community draws up an action plan that actions coping strategies they have identified as particularly effective.	Macro level – Governments and funding agencies have confidence in local knowledge and abilities to develop solutions Community level – The community accepts that they should participate in community life and have a sense of confidence in local strengths. Family/Household level – Foster parents and children are involved in the participatory process, giving input on the kind of support they need or can offer the project.	CCCT or similar PLA interventions are implemented to facilitate reflection and strengthen the psychosocial well-being of marginalised groups. Community members can actively draw on the resources available within the community setting. Household members show their support by contributing to the process and speaking out of their needs and circumstances.
Cash is transferred to the project management committee and the target community starts implementing their proposed activities e.g. goats keeping, farming using oxen and plough or income generating activities	Macro level – Financial and political stability and decent infrastructure ensures a smooth running of the intervention. Community level – The target community accepts ownership of and responsibility for implementing the programme. Family/Household level – Household members encourage the active participation and hard work of orphaned children	Support programmes distribute adequate and timely resources, such as facilitation and money. Community members have access to much valued resources and confidently take on the responsibility to implement the action plan. Household members are supportive and loving and encourage children to participate.
The community observes and evaluates the programme and its progress, resulting in positive suggestions as to how the programme can be improved. The cycle of CCCT starts over (with or without a second transfer of cash)	Macro level – Governments and funding agencies continue to support promising communities Community level – The community is aware of factors that support or hinder the success of the programme. They have confidence in their abilities and strengths to tackle challenges, and continue the programme through e.g. seeking new funding avenues. Family/Household level – Household members are aware of more ways to access support and see changes to their well-being.	Formal evaluations indicate that community competence and self-efficacy has developed as a result of the participation of community members in an effective project. Community competence and self-efficacy has developed as a result of the community's sense of ownership and confidence in their ability to provide effective support to children affected by AIDS Children are happier and healthier as a result of improved coping strategies.

In this table 'community' refers to a community of shared circumstances, 'wider community' refers to a geographic location. This model is adapted from Prilleltensky et al. (2001) and has been reworked

The model presented in Table 4 outlines the potential of CCCT in either building or further enhancing the social psychological resources that make up an OCC. Different communities might have some, all or none of the social psychological resources that I believe constitute an OCC. For that reason, the resulting qualities presented in this model can also be indicative of the enabling qualities that characterise OCC, providing a framework that allows service providers to identify areas of need.

Much of my conceptualisation of an OCC can be rightfully challenged, depending on how one approaches the project. Not least for some of the many limitations that community-based and participatory programmes present. The next section will declare some of these limitations.

2.5 Community and participation revisited

Some might argue that my account of community participation is naive because it neglects the often hierarchical and exploitative social relations that typically characterise marginalised communities (Cornish & Ghosh, 2007). Having said that, the most challenging aspect of doing participatory and community-based work is that 'community' and 'participation' means many different things to different people (Rifkin, 1986). Perhaps for that reason, Petersen and Lupton (1996:159) claim "that it makes little sense to speak of 'community participation' in any abstract, trans-cultural sense. The meanings and implications are always dependent on the contexts of use, and on the structural location and continuing commitments of parties." In this section I will therefore engage in a debate relevant to the terms used in this study.

2.5.1 'Communities' and their members

In the introduction I briefly outlined how I defined community in the context of this thesis. Community is a highly contentious phenomenon, which deserves more careful consideration than the definition that I, for practical reasons, have used in this thesis.

Although I fully accept the many different types of communities that flourish within a geographical locality, I have for practical reasons used community to refer to the inter-dependent system that exists within a geographical area. However, the different communities and community-based programmes that exist within a geographical location are likely to be influenced by complex interactions between various types of communities and identities that individuals or households see themselves belong to (Clever, 2001). A school going caregiver may for example struggle reconciling the identity of being a diligent student as well as being a devoted caregiver, simply because there is not enough time to do both. Perhaps because community membership is so fluid, the resources available within a community may not be readily available as people and households shift their membership between communities. This is particularly relevant in times of hardship where resources are scarce. Cleaver (2001) argues that 'resourceful communities' is a myth. She believes that structural and resource constraints impact on otherwise dynamic, motivated and well organised communities. If this is true, there is all the more reason to implement CCCT, providing the

communities with the much needed resources (and incentives) they require to return as dynamic, motivated and organised communities. However, whilst I fully believe in the capabilities of communities, I do not want to romanticise communities and I do not assume that community members always have the good of OVC at heart. As this research will bring forward, many OVC are subject to abuse and neglect by people within their own communities.

2.5.2 Uses and abuses of participation

Community participation has become a catch-all concept. Differing definitions of community and the conceptual blurring around the terms 'participation', 'participant' and 'participatory' have created a space for diverse applications and confusion (Cornwall & Jewkes, 1995). Community participation can therefore be used not only to enable local people to seek their own solutions, but also to secure funding or to convince local people into the agendas of others with a more top-down approach (Cooke & Kothari, 2001).

Much has been written on participation (Campbell & Jovchelovitch, 2000; Mosse, 2001; Rifkin, 1996). Its popularisation has meant that it has become not simply a right, but a duty (Petersen & Lupton, 1996). Critics claim it has become an act of faith in development: something to believe in but rarely question, with the result that an understanding of the processes whereby participation might achieve beneficial effects is still in its infancy (Campbell, 2003; Cleaver, 1999). Due to the many opinions of participation it is important that this debate does not discuss whether or not participation works, but in what context and what approach and attitude is necessary to make it work. Arnstein's (1969) 'Ladder of Participation' (see Figure 6) provides a useful tool to analyse the approach and attitude adopted by the facilitators.

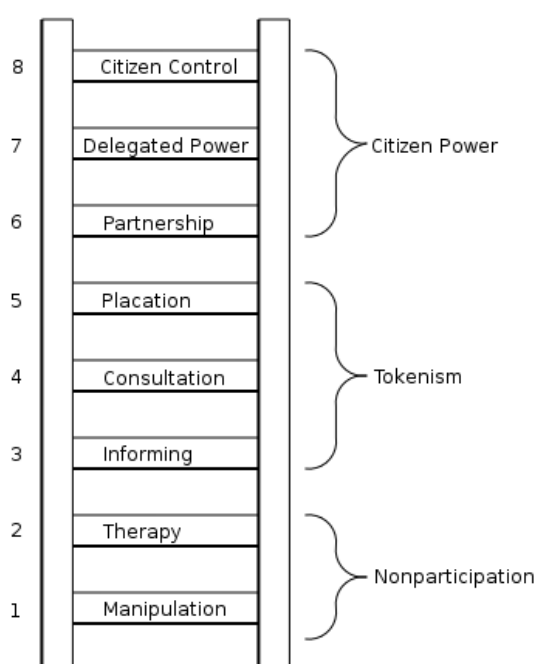


Figure 6: Ladder of participation

Arnstein's ladder allows us to see participation on a continuum, at one end participation is either non-existing or tokenistic and only involves informing people about their rights and the programme about to be implemented and on the other end; community members have complete control and power of the programme. These are approaches to participation that are dependent on attitude and context. Although the ladder by Arnstein is useful, a simpler categorisation by Khassay and Oakley (1999) will be used to illustrate how I simultaneously drew on different understandings of participation.

- i. *Participation as collaboration:* In this kind of participation, the community collaborates with the service provider in completing a project, typically a project set out by the service provider. Community members may therefore be used tokenistically to contribute to the project. This type of participation is likely to present opportunity costs to the beneficiaries and does not directly promote empowerment. The majority of my research activities belong to this category. Whilst the children participated and had some role to play in guiding the course of the research, they did not participate as a result of research questions they had formulated collectively. Our collaboration was guided by me and a research agenda I had formulated.
- ii. *Participation as specific targeting of project benefits.* The aim of this type of participation is to include previously excluded groups, such as young carers or elderly guardians. These groups may be involved in different stages of the project or study, often when doing a needs assessment. However, this type of participation remains at the level of consultation and although I may have modified certain pre-planned activities, such as the workshops where my research methods were tested and disseminated, in light of local people's responses, I did not have to.
- iii. *Participation as empowerment.* Here participation is an exercise of empowering people. Following this approach, the children participating in this study did not simply accept my instructions to carry out pre-planned activities. Instead, the children participated in gathering and interpreting the information for a needs assessment. They participated in identifying and prioritising problems, finding solutions, carrying out activities and subsequently evaluated them. My action research project strived to engage the children with this approach to participation. I may have succeeded at some steps, such as involving children in finding solutions, but less in others, such as evaluating the project.

What transpires from these different categorisations of participation is that even within my own project, I draw on different levels of participation. In some aspects of the study the children are merely collaborators (primarily during research activities) and in other aspects, participation is used as tool to give the children power and control (primarily during the intervention). Nevertheless, my constant shifting between different levels of participation, tells me that there are moments where less participation may have a role. For example, if it had not been for my personal initiative in deciding to do this study, we would not, at this moment in time, have learnt about the collective struggles and coping strategies of young carers in Western Kenya. This is not to say that my study

is better because I initiated it, than if the children contacted me and asked me to facilitate the study. On the contrary. However, it does suggest that there is a role for different levels of participation.

In this section I have briefly highlighted some of the difficulties that arise from doing a participatory and community-based project. I have acknowledged different understandings of 'community' and 'participation' and located myself within these debates. These challenges suggest that enhancing or strengthening a community's social capital is not an easy task following the complex and dynamic nature of communities (Arneil, 2006).

Conclusion

This chapter has presented the framework which guides my proposed social psychology of coping. It has drawn on a number of theories, integrated some and modified others. As my approach to coping is to strengthen and support, I suggested salutogenesis as the guiding principle behind this study and located myself within community health psychology.

Before moving on to my initial conceptualisation of an OCC, I drew on and contextualised the existing literature on coping and resilience. In the past people have identified coping as an individual process of adaptation to social circumstances (focusing mostly on cognitive and affective factors), without enough attention to the role played by community memberships in enabling or hindering effective adaptation (cf. Antonovsky, 1987; Folkman & Moskowitz, 2000; Lazarus, 1966; Lipowski, 1970; Murphy, 1962). Whilst the likelihood that a young carer will cope is dependent on many things, such as genetics, upbringing, cognitive and social protective factors, in this chapter I focused largely on the neglected community level of analysis. In doing so, I have argued that a key determinant of coping is the extent to which the individual is able to participate in their local community life, and the extent to which the local community provides constructive opportunities for this.

Having established the need for a social psychological understanding of coping, the core section of this chapter proposed a five-point conceptualisation of an OCC, highlighting some of the social psychological resources that can facilitate coping. These were appropriate knowledge and life skills, building awareness in local strengths, and agency to mobilise these, economic and political ability to participate in community life, solidarity and partnerships and finally supportive social spaces. This conceptualisation was partly inspired by Campbell and colleagues' (2007) conceptualisation of AIDS competent communities and partly grounded from initial observations of my data. To contextualise the tool within a wider policy framework, I integrated Woolcocks (1998, 2001) framework of social capital into my explanation of the five dimensions.

I then looked at how participatory processes could make OCC actionable and explored the steps of CCCT and the potential pathways between this participatory intervention, OCC and coping. The participatory nature of my intervention and conceptualisation of coping, required me to briefly touch

on some of the limitations of working within a framework of community participation, but concluded that even 'imperfect' participatory programmes can have a positive impact.

Based on my review of the existing coping literature and an exploration of health-enabling and social psychological processes within the community health psychology literature, leading to a five-point conceptualisation of an OCC that facilitates coping, I will argue that one cannot understand coping as an individual process. Reflecting my conceptualisation of an OCC, coping should be seen as a collective effort whereby individuals are able to negotiate and access support from community members who draw on local resources, networks and responses. I will draw on this theoretical understanding to explore and investigate the resilience and coping strategies of young carers.

Chapter three will contribute further to the development of a social psychology of coping through its discussion of participatory action research, as it presents the methodology used in this project. The chapter also presents the research methods I have used to explore the coping strategies of young carers and how I analysed my data.

Chapter 3 - Methodology and research design

Introduction and chapter overview

This chapter sketches the methodology and research design used in this study. To put the chosen methodology into perspective, I will first discuss the epistemologies that guide this study. I will then explain my choice of field research site and how the data were collected. This will be followed by an account of how I analysed the data and developed a series of thematic networks. Reflecting on my own experiences of the research process, the fourth and final section of this chapter will look at some of the ethical and social dilemmas of doing research with children.

3.1 Doing research *with* children

The social study of children has over the past twenty years benefited from new theoretical and interdisciplinary perspectives that view children as social actors (Holloway & Valentine, 2000; James & Prout, 1997). The fact I am doing research *with* children, as opposed to *of* or *for* children echoes a paradigm shift in understanding children and childhood. This development has sparked innovative research methods and widened methodological discussions (Christensen & James, 2000; Greig & Taylor, 1999). In this section I seek to draw on and reflect on some of these methods and discussions in relation to their epistemological position.

3.1.1 Study methodology and epistemology

“Sometimes we simply have to keep our eyes open and look carefully at individual cases – not in the hope of proving anything, but rather in the hope of learning something!” (Eysenck, 1976:9)

Methodology refers to the general approach to studying a research topic (Silverman, 2005). In my case, this includes all aspects of research practice with children: the theory behind methods, data analysis and representation of findings. It also includes a transparent and reflexive account of the epistemological approaches that guide the study.

Mirroring the words of Eysenck, this study seeks to understand the social world from the point of view of the children living in it. Three distinct epistemological approaches inform my implementation of this guiding aim. Firstly, the study is phenomenological in its focus on the experiences of children providing care and support to/for ailing or ageing guardians. Secondly, the study is located within an interpretivist paradigm that acknowledges the need to understand and capture meanings and subjective experiences (Greig & Taylor, 1999). Lastly, and reflecting my theoretical framework (see Chapter two), this study is guided by constructivist principles, arguing that children construct ways

of living in interaction with their guardians and the wider community in which they are engaged. My PAR project aimed to provide opportunities to enhance, develop and strengthen the children's coping responses.

3.1.2 Children's perspectives

Mainstream psychology has been in the forefront of developing a cognitive map of how individuals progressively define their membership of an adult society (Piaget, 1929). This traditional approach interprets children's perspectives according to their developmental level and sees children as incomplete and vulnerable beings in need of adult guidance and support until they have reached adulthood or adult rationality. Although Piaget (1929, 1953) does acknowledge that children learn from participating in their lifeworld, including from other children, this is limited by children's biological constraints and developmental stage. Whilst I accept that children do have biological limitations, I am concerned about the labelling and use of developmental stages to determine the capabilities of children. These labels can be used to describe what children can or cannot do, in ways that fail to acknowledge that children often have to perform tasks that do not fit rigid definitions of their age-related developmental status. I therefore align myself alongside writers of human and cultural geography, who accept the possibility that children, across developmental stages, are active and competent beings in their own right (Christensen, 2004; Holloway & Valentine, 2000; Matthews, Limb, & Taylor, 1998) and that the labels that are used to describe their social marginalisation are socially constructed.

Nevertheless, due to the hegemonic nature of Piaget's developmental theory, the perception that adults know better, particularly as they have once been children themselves, and so can act as experts on their behalf, continues to inspire many methodologies of child-focused studies (Matthews et al., 1998). However, if one accepts children as social actors with diverse opinions and views about their lifeworlds, the challenge is to capture the varying perspectives in a way that reflects their capabilities and will not intrude, harm or misrepresent (*ibid.*).

Capturing the perspectives of children does not necessarily mean adopting different methods and ethical guidelines to research with adults, however, it does mean that we should try and adopt methods and ethical guidelines capable of identifying the skills and competencies of the children under study (Christensen & James, 2000; James, Jenks, & Prout, 1998; Punch, 2002). According to Punch (2002), research with children has until recently followed two extreme approaches. In the first approach, researchers used the exact same methods as with adults, treating adults and children exactly the same. However, as Morrow (1999b) notes, such an approach may neglect the power differences between the child and the adult researcher. At the other extreme, researchers saw children as entirely different and used ethnographic methods to gain an understanding of the child's perspective. But as Hill (1997) suggests, ethnography relies on participant observation, which is limited by the fact that an adult will never be able to fully participate as a child again and understand childhood in a different context.

Referring to the two extremes, Punch (2002) argues for a mid-way approach that takes into consideration the limitations of adult-centred approaches in doing research with children and gives examples of methods she has successfully used in a class-room setting. These include drawings, photography, diaries and worksheets, methods I will be drawing on. Such multi-method techniques are increasingly adopted to recognise and support the different ways in which children feel most able to share their experiences and perceptions of a phenomenon (Greig & Taylor, 1999; Johnson, 1998; O'Kane, 2008; Woodhead, 1998), an approach which has also recently been used in studies with young carers in Nicaragua (Dahlblom, Herrera, Peña, & Dahlgren, 2009) and Tanzania (Evans & Becker, 2009). Aside from eliciting different perspectives from children in a fun and interactive way, some of these methods, including the use of photography, have been conceptualised as PAR methods with the potential to empower research participants (Rifkin & Pridmore, 2001; Wang, Yi, Tao, & Carovano, 1998). I will return to PAR shortly.

To strengthen/optimize children's position as research participants, I too used multiple methods to collect data. Drawing on PLA techniques, the researcher and field assistants (discussed further below) held workshops collecting historical time lines, daily diagrams and community mapping to get the children thinking about the context of their circumstances, preparing them for more elaborate explorations using photography (Chapter seven gives detail of these workshops). The initial workshops also gave me an opportunity to get to know the children and their backgrounds. In addition to using more conventional individual and group interviews, I also used methods such as photography, written narratives and draw-and-write exercises to enable the children to share their perspectives. These methods are described in Section 3.2.4.

Although multi-method research and child-friendly methods are increasingly advocated for research *with* children, such approaches have more recently been accused of being antithetical to the stance taken by most of the researchers who advocate participatory methods to highlight the competence of children. Gallacher and Gallagher (2008), for example, argues that child-friendly methods engages with the children as adults-in-the-making and that 'participation' of children in the research is being abused because of the popularity of doing research *with* children. They also argue that "to encourage children to participate in creating knowledge about themselves is also to encourage them to take part in the processes used to regulate them" (ibid.:504), something the children very rarely are aware of. Such critical views are important reminders of the complex nature of doing child-focused research.

Nevertheless, aside from giving children the opportunity to participate, the multiple methods used over a long time period were also selected to raise the lead investigator above personal bias, giving me an opportunity to triangulate findings. Additionally, Flick (1992) argues that data collected from different sources at different points in time, can provide varied perspectives of the same phenomena, enriching the data corpus.

3.1.3 Participatory action research

In this thesis I have outlined my interest to involve the children in a participatory process to develop practical solutions (see Chapter two). I have declared my commitment to bring forward children's perspectives and to bring together action and reflection, highlighting and addressing issues of concern and interest. As a result, the orientation of inquiry guiding this thesis is participatory action research. According to Minkler (2000:192) "the term *participatory action research*, or PAR, has increasingly been used as an overarching name for orientations to research practice that place the researcher in the position of co-learner and put a heavy accent on community participation and the translation of research findings into action for education and change". PAR is a practice for the systematic development of knowing, but different from traditional academic research in that it is based on a different relationship between the researcher and the researched, has different ways of perceiving knowledge and its commitment for practical outcomes (Reason & Bradbury, 2006b). The relationship between the researcher and the researched in PAR reflects the theories of Paolo Freire. In the context of education, Freire (2005) argues that learners should be treated as active participants and teachers should join the learners in their struggle for liberation. He says: "the important thing is to help men (and nations) help themselves, to place them in consciously critical confrontation with their problems, to make them the agents of their own recuperation." (Freire, 2005:16). In such a relationship everyone is an expert and has got something valuable to say and contribute within the research process. This clearly differs from the didactic relationship that characterises more conventional research, such as structured interviews or surveys, between the researchers and their subjects (Reason & Bradbury, 2006a). To further highlight the differences between traditional research and PAR, I will now turn to discuss some of the key features, as outlined by Reason and Bradbury (2006), that characterise PAR as an orientation of inquiry and relate them to this study through examples.

A primary purpose of PAR is to produce practical knowledge that is useful to people as they go about living their lives. A wider purpose of PAR is to subsequently translate this knowledge into actions that will contribute to the increased well-being of those participating. Drawing on the example of this study, young carers got engaged with photovoice, community mapping, history and daily diagrams, reflecting and generating knowledge about their circumstances and coping strategies. As will be outlined in Chapter seven, this knowledge was translated into action plans that the children subsequently implemented to improve their well-being and coping capacities. In the process of working with children in similar circumstances, the children gained confidence and learned new coping skills and strategies from their peers. Both Rifkin and Pridmore (2001) and Reason and Bradbury (2006) have highlighted the importance of the process in PAR, indicating its emancipatory potential. The PAR process leads not only to new knowledge, but also strengthens the ability of participants to create new knowledge and take new initiatives that can help them further. The young carers participating in this study for example, upon learning new skills (e.g. building a chicken shed using locally available materials), might gain enough confidence to develop them further (e.g. building bigger chicken sheds or of a higher standard). Similarly, the research, inquiry and decision making skills the children have gained from participating in this project, coupled

with a sense of self-efficacy, may prove useful in future endeavours and their search for social change.

I spoke about the relationship between the researcher and the researched earlier. I highlighted how a key element of PAR is to give control of the information generated to the intended beneficiaries and for professionals and local people to learn from each other, creating a synergy of knowledge sharing and generation for practical solutions. To this end, Reason and Bradbury (2006) argue that PAR is not about producing academic theories, nor is it about producing theoretical and empirical knowledge that can be applied in action; it is about liberating the human body for a better, freer world. As the write-up of this thesis testify, my relationship with the intended beneficiaries is not one of equality. The participating children did not write the overarching research questions and they have not contributed to the writing of this thesis. Nor did the PAR project seek to liberate the human body – it merely sought to strengthen the coping capabilities of caregiving children. Caught within an academic institution, working towards a PhD, and with an interest to generate knowledge that can policy implications at national and trans-national level, this PAR differentiates between the children's aims and objectives in participating in this project, and my own intellectual aims and objectives. The caregiving children participating in this project had complete control over the kind of information they gathered (through photovoice) and how they wanted to use this information to develop practical solutions. The children however had less control about how I analysed and interpreted their information. Furthermore, as the forthcoming section will outline, this study also applied more conventional research methods such individual interviews and group discussions. This differentiation between their objectives and my objectives may be argued by some devoted PAR practitioners to undermine the principles of PAR. Whilst this does present a limitation, Reason and Bradbury (2006) in their edited book on PAR, give indication to the many uses of PAR as an orientation of inquiry.

The fact that PAR means different things to different people and is applied in many different ways presents a number of limitations (and abuses) to the term. The aforementioned sections introduced PAR and some of the principles behind PAR as an orientation of research inquiry. What is evident from this introduction is that there are striking parallels between PAR and the principles of community participation and mobilisation – that could use participatory rural appraisals as conceptualised by Chambers (1997). According to Minkler (2000), both are ground up rather than top down driven; both use democratic participatory processes and social learning; both emphasise the strengths of people and communities; both should be driven by community priorities and neither can be done following a recipe. As a result of their similarities, some of the concerns raised about community participation (for examples, see Section 2.5) also apply to PAR, some of which I will now present.

Although PAR presents greater visibility of the researcher and transparency than conventional research, it still presents a number of challenges. As is the case of this thesis, theoretical writings of PAR may not be followed due to the complex environments and contexts in which PAR takes place, this includes the fact that this PAR project has to fall within institutional PhD requirements. Cornwall

and Jewkes (1995:1672) argue that “control over the research is rarely devolved completely onto the ‘community’; nor do ‘communities’ always want it.” Local people may be highly sceptical as to whether they should participate due to the opportunity costs and this may be even more so when marginalised groups are accessed through community guides (gate keepers). Relating it to this study, there were ethical dilemmas in reaching caregiving children through community guides. Were some of the caregiving children forced to participate against their will? Would they have the power to tell the community guide that they do not wish to participate? These questions highlight the importance of being aware of the power relations within the community and the extraordinary challenges faced when working with children. Existing power structures can enforce the agenda's of the powerful, working outside and against these structures can influence the potential impact and according to Cornwall and Jewkes (1995), invite continued marginalisation. Also the professionals working with the intended beneficiaries can use PAR to impose their agenda (Chambers, 1997). Cornwall and Jewkes (1995) for example argue that the ideals of democracy used to advocate ‘participation’ in research can amount to little more than western cultural imperialism. This suggests that PAR may carry more significance for outsiders than it does for the poor.

To this end, some communities may be uninterested in taking part in the research as the enthusiasm for local knowledge may lack local relevance (Cornwall and Jewkes, 1995). Also, if the research challenges existing power structures, those with the upper power may not wish to see the local relevance. To Chambers (1997:76) power is coercive and repressive and states: “For learning, power is a disability”. Challenging such power relations and status quo may be detrimental to the community under study and may leave them more vulnerable, marginalised and exposed in some hostile environments (Cornwall & Jewkes, 1995; Khanlou & Peter, 2005).

In this section I have used expert or professionals to refer to those facilitating the intended beneficiaries. Echoing a Foucauldian argument, the use of such binary opposites, frame knowledge and suggests that power is part and parcel of PAR, despite its attempts to banish power. Although PAR promotes collaboration and partnership, the prevailing binary ontology of lay/expert may undermine the stated intentions of PAR. According to Kapoor (2002), this facilitating role is double edged as it may further empowerment, but it may also produce surveillance and discipline. In a continuing spirit of Foucault, this may be PAR's ‘panoptic’ dimension, where participants, community members and ‘experts’, monitor and normalise one another's behaviour. It could therefore be argued that this study, despite its participative commitment, serve to monitor, label and address the circumstances that characterise the lifeworlds of caregiving children.

With regards to ethics, PAR has a few distinct challenges (Khanlou & Peter, 2005), some of which have already been mentioned. In an ideal PAR situation, it is unclear who should be giving and obtaining informed consent, as community participants and the external persons with specialised training are all referred to as ‘researchers’. Khanlou and Peter (2005) suggest that the initiators of the PAR should be responsible for obtaining informed consent. However, PAR can also address some of the ethical dilemmas that may be encountered during a research inquiry. Nyambedha (2008), for example, through his long term research project on OVC in Western Kenya, comments

on the responsibility researchers have when doing research with children in resource poor settings. Based on his own experiences, he notes the ethical dilemma of not supporting the children under the study, arguing that their participation in a study may well be influenced by an underlying expectation of assistance. Nyambedha therefore recommends researchers to be innovative in designing action research projects that both collect data and provide support (in line with their expectations) to the children participating in the study – an ethical dilemma this study aims to overcome.

In this section I have outlined the principles of PAR and in so doing highlighted how PAR is different from traditional research methods. I have positioned this study within these principles and discussed some of the limitations of PAR. Considering the PAR principles, the diverse use of PAR and the limitations presented, it appears that a key element of PAR lies not in methods but in the attitudes of researchers. Reason and Bradbury (2006) believe it is the attitude or world view of the researcher which determines, how, by and for whom PAR is conceptualised and conducted. I will in the remaining sections of this chapter outline how I, guided by the PAR orientation, have made use of various research methods.

3.2 Study design and data collection

This section presents and reflects upon the study design. Study design refers to how the study was planned, conceptualised and carried out. Table 5 provides an overview and timeline of some of the key stages of this study. As illustrated by the table, this study comprised of two phases. Phase one explored the circumstances and background to young caregiving, serving as a needs assessment for the children involved. Phase two evaluated the intervention and explored the impact of the children's participation in this project as well as looking at their agency and competence. However, as the forthcoming subsection will show, the content of these two phases changed from what I had initially planned. The remaining subsections will elaborate on how I chose the study area and the methods used to collect and analyse my data.

Table 5: Project timeline

Steps & activities	Time (quarterly)										
	Q4 2006	Q1 2007	Q2 2007	Q3 2007	Q4 2007	Q1 2008	Q2 2008	Q3 2008	Q4 2008	Q1-3 2009	
PHASE ONE											
Proposal write-up and submission	■										
Ethics approval (LSE & Kenya)	■										
Mobilisation of communities	■										
Identification and assessment of young carers		■									
PAR exercises (History profile, daily diagram & community maps)			■								
Photovoice and draw-and-write exercises				■							
Interviews with young carers and adults (on their circumstances)				■							
Transcription and translation of data				■	■						
Writing of caring essay					■						
Data analysis					■	■	■	■	■	■	■
Young carers write up action plans					■						
Implementation of action plans					■	■	■	■	■	■	■
Interviews with social development professionals							■				
PHASE TWO											
Interviews with young carers and adults (evaluation of intervention)										■	■
Draw-and-write exercise										■	■
Writing of team work essay										■	■
Field/study sights were visited fortnightly and field notes were kept throughout the project by fieldworkers and lead investigator.											

3.2.1 Initial plans and changes

This project has seen a few changes in the process. Two contrasting communities were identified for this study with the aim of exploring any impact of the NGOs in the area on the processes under study, namely the way in which children cope with adversity. However, as little difference was observed, the data were collapsed into one pool. I will, however, still explore and flag up differences between the two communities wherever they occur, acknowledging that these differences are not always due to the NGOs presence, or not, but also due to leadership and educational experiences.

I planned to conduct my study over a two year period from 2007-2009. After some initial preparations in the latter quarter of 2006, I duly started off with the research in 2007. However the study got interrupted by unexpected political events for three months starting 27 December 2007. On this day a general election in Kenya was to decide its future President. However, as it became clear that opposition leader, Raila Odinga, was in the lead, the acting President of Kenya, Mwai Kibaki, was reported by international observers, as well as the opposition party, to have rigged the election results in his favour and he declared himself as the continuing President. Protests quickly escalated into violence and destruction of property and infrastructure. At least 1,500 people got

killed and 300,000 people were displaced during this conflict. With Bondo being the birthplace of the opposition leader, the conflict had a catastrophic impact to the day-to-day lives of people in the district. Violence and inflation meant that livelihoods were shattered by the conflict. The conflict also had an impact on the intervention under study, with young carers migrating or preoccupied with added responsibilities and school work, making up for two months of school absence as a result of the conflict. It was my aim to explore the outcome of the intervention under study. Whilst this is still possible, the low number of children still active in the intervention and the impact of the interruption caused by the conflict undermined the intervention and therefore the validity of an evaluation of its impact.

3.2.2 Study area

The study was conducted in Bondo district of Nyanza province in Western Kenya. The district lies along the shores of Lake Victoria and is inhabited by the patrilineal Luo ethnic group (Nyambedha et al., 2003a). I first visited and got familiar with Bondo in 2004 when I was working for an international NGO that had an office and carried out activities in the district. I quickly realised the impact of HIV/AIDS on people in the district and focused all my work on the district. As I departed from the NGO in 2005, I decided to establish a NGO (called WVP Kenya) in Bondo with local friends, aiming to improve the health and well-being of children and youths. We are currently providing long-term support to over 1,000 OVC, of which 410 have been provided with educational scholarships.

Poverty is a major challenge for people in Bondo district. With 68.1% (of 260,000 people) living in absolute poverty, it is the third poorest district in Kenya (GOK, 2006). Bondo is also one of the districts in Kenya with the highest rates of HIV. In 2004, the HIV prevalence rate of Bondo district was estimated to be 13.7%, which is two-fold the national average (NACC, 2006). As a result of high HIV/AIDS prevalence rates, many children in the district have had their livelihoods affected by AIDS. A survey done by Nyambedha and colleagues in Bondo in 1999 found that one out of three children (33.6% of the 724 sample size) had lost one or both parents and one out of nine children had lost both biological parents (Nyambedha, 2008; Nyambedha et al., 2003a).

To reach a fair number of young carers, two communities (Moja and Mbili; pseudonyms) were purposively identified to participate in this study. The research team met a number of communities, but made a conscious effort to ensure that both communities shared a similar geography (access to water and soil quality) and socioeconomic status (quality of huts) and would be representative for the rural community in Bondo as a whole. See Figure 7 for their location in Kenya.



Figure 7: Map of Bondo, depicting the two participating communities

For me, Bondo was the obvious choice of study site, due to my personal interest and knowledge of the area, but also due to the infrastructure that I and my Kenyan friends had in place in the district. The infrastructure, contacts and trust we had established as an NGO, served as an important facilitator of my access to informants, as well as giving me valuable background knowledge within which to contextualise my findings.

3.2.3 Study participants and duration

When I and my two research assistants first met the children and community members of Moja and Mbili in April 2007, we discussed the sampling of young carers. My initial criterion was to include children who provided more than 20 hours of care and support to their household per week. However, members from the community told me that many children without sick guardians could work up to 20 hours and we agreed on a more open, yet specific criterion, that the children had to provide 'above average' care for a parent or guardian, meaning they would have to engage in activities that extended beyond what would normally be expected of them. This assessment was done in dialogue with my local research assistants and women from a local community organisation who served as community guides (gate keepers). A total of 24 children from each community were nominated (see Table 6 for selection criteria). I do not know if the community guides identified more than 24 children and what their internal criteria was to include or exclude some children. However, our criteria were that the children had to be between ages 12 and 17, old enough to articulate their perspectives using my proposed methods and young enough to be defined as an OVC.

Table 6: Selection criteria

Inclusion criteria	Exclusion criteria
- Children in the ages 12-17	- Children older than 17 or younger than 12
- Children that provide above average care for a parent or a guardian	- Children living outside the threshold of the project
- Children who have given consent	- Children unwilling to participate
- Children whose parents/guardians have given consent	- Children not identified to provide above average care to a parent or a guardian
	- Children whose parents/guardians have not given consent

To ensure the children fell under these criteria, an acceptance interview, using a structured questionnaire to obtain basic demographic characteristics (see Appendix 1) was administered to each of the 48 children in May 2007, marking the start of a 21 month research project which ended February 2009. All 48 children put forward by the community guides were accepted. As we followed the same children for the entire period, we consider this study longitudinal. Table 7 summarises key characteristics of the study participants, gathered from the acceptance interview.

Socio-demographic characteristics	n	%
<i>Gender</i>		
- Girls	28	58%
- Boys	20	42%
<i>Age group</i>		
12-14	29	60%
15-17	19	40%
<i>Orphan status</i>		
- Paternal orphan (child lost its father)	30	63%
- Double orphan (child lost both parents)	9	19%
- Social orphan (child vulnerable to poverty and parental illness)	6	12%
- Maternal orphan (child lost its mother)	3	6%
<i>Guardian (whom they live with)</i>		
- Mother	24	50%
- Grandmother	10	21%
- Aunt	7	15%
- Sister	3	6%
- Father	2	4%
- Nobody	2	4%
<i>Care recipient (whom they currently care for)</i>		
- Mother	25	52%
- Grandmother	9	19%
- Aunt	7	15%
- Grandfather	3	6%
- Neighbour	2	4%
- Father	1	2%
- Sister	1	2%

Table 7: Socio-demographic characteristics of participating children

The level of engagement by the 48 participating children differed significantly (see Table 11 for an outline of who participated in the various research activities). Some children had more time to

participate than others; some had more to gain, either as a result of their position within the project (the children elected a project management committee) or as a result of their interest in contributing to the study. The longitudinal nature of this project also meant that retention was difficult. Four of the participating children lost a parent during the course of the study and migrated to stay with extended family, others took on more caring responsibilities and did not have the time to participate and some simply lost interest in participating. Counts of the number of active participants at three different stages of the project demonstrate the dropping number of participants (see Table 8).

Having said this, it was important for me that the children at no point felt they *had* to participate in this study and that they could communicate their stories when and how they felt most comfortable. Although a multi-method approach was adopted in this study to provide the children with a space and tools to participate in the study more or less on their terms, this was not enough to keep the children involved. Nevertheless, as the children themselves decided when and how to participate, the views of some children are more dominant than others. This self-selection and the reduced number of active participants also presents a major limitation to the ‘evaluation’ of the project as only 21 (of initially 48 children) of the 29 active remaining children had time or were willing to participate. For details on who dropped-out and who participated in the various research activities, please refer to Table 11.

Table 8: Retention of child study participants

Stages	Number of active children
Beginning (May 2007)	48
Middle (March 2008)	33
End (February 2009)	29

To gain as many different insights to the phenomenon of young caregiving as possible, 16 adults were purposively selected to participate in this study, either as a result of their position within the community (community guide, community elder, CBO member) or district (children’s department officials or social development officer) or because of their relationship to the participating children (e.g. guardians). These 16 adults were interviewed using semi-structured interview guides (see Appendix 3). In addition, 31 self-selected adult community members spoke of OVC and young caregiving in two group discussions (see Table 9).

Table 9: Adult participants

Adults	Number
CBO member	4
Guardians	6
Social development professions (SDP)	4
Village elder	1
Teacher	1
Community members (group disc.)	31

3.2.4 Obtaining data from the field

This subsection consists of a narrative account of the methods that were used in this study, followed by a summary table on page 106. Within the interpretative perspective adopted, the data were collected through a 21 month period with two phases. To get more of an ethnographic insight to the lives of the children and to stay familiar with possible changes to their caring circumstances, a youth club for children providing care for adults was established in each of the two communities. If time allowed, the children would show up on designated community grounds (near a church or nursery school) over the weekends and meet other children in similar circumstances for peer building activities. An average of 9 children enthusiastically did so every Saturday or Sunday. The youth clubs were run by field/research assistants who were employed by WVP Kenya. WVP Kenya was established with the research funds available to this project and has since grown into a NGO with an annual income of £120,000, raised from overseas sources by the author, from which the young carers participating in this study will benefit. The research team provided the youth clubs with footballs and volley ball equipment, pens and paper, encouraging creative and collective activities and visited the clubs weekly or fortnightly. It was within this framework data was collected and I will now go into detail of each of the methods used.

Use of field assistants

Data collection and facilitation of the youth clubs were done by two local Dholuo speaking field assistants, one man and one woman. Although there are many advantages to the lead investigator collecting data himself, there are certain constraints that may circumvent these advantages. As a 'Mzungu'⁵ doing research in a poor and rural African community, I had to be aware of the power imbalances and perceptions local people had of me and how these representations would influence the data, had I interviewed the children myself. Both Punch (2002) and Morrow (1999b) note the importance of building rapport with participating children and adults. Due to practical limitations such as my inability to communicate in the local Dholuo language and the fact I was unable to stay in Bondo for the duration of the project, it would have been difficult for me to build optimal rapport with the children – something the field assistants managed to do.

Additionally, the use of more than one local investigator provides investigator triangulation, which according to Flick (1992) reduces the subjective bias from one investigator. Although this study is interpretative and will never fully depict an objective reality, the inclusion of field assistants in the data collection, analysis and interpretation may provide a more balanced account through triangulation of each of their perspectives and my own.

I have known the field assistants involved in this study since 2005 where I trained them as field assistants for my MSc project. Celestine Aoro is a 23-year-old woman who grew up as a paternal orphan. Celestine lived her whole life in Bondo and is educated to secondary school level and currently working for WVP Kenya as a Monitoring and Evaluation officer. Vincent Onyango Ogutu is also 23 years old and works for WVP Kenya as a Programmes Manager. Vincent is also educated

⁵ Mzungu refers to a foreigner and means white man and is connotated to wealth and access to support

to secondary school level. To ensure consistency and quality interviews, Cellestine and Vincent went through a checklist prior to each interview (see Appendix 2).

Developing and testing topic guides

The initial topic guides were based on a free listing exercise done by myself as lead investigator and the two field assistants. They were developed in English and translated into Dhluo. To sensitise Cellestine and Vincent to the study and to test the topic guides (see Appendix 3), we conducted two small pilot interviews. Themes arising from the interviews were discussed and only minor changes to the topic guides were required. Two questions had to be re-translated, as the translation did not fully reflect the issue that would address my research questions, and we discussed additional possible follow-up questions.

PLA workshops

I mentioned briefly in Section 3.1 the uses and types of PLA exercises that were used to sensitise the young carers of their circumstances. From a research perspective, these exercises also generated data that helped the research team place each individual child within certain structures and life events (Gramling & Carr, 2004). I drew on four PLA exercises from Rifkin and Pridmore's (2001) book *Partners in Planning*.

1. Community Social Maps (see Appendix 4)
2. Historical Profiles (see Appendix 5)
3. Daily Routine Diagrams (see Appendix 6)
4. Draw-and-write exercises (see Appendix 7)

The first three exercises involved the drawing of a map and two diagrams. The social maps allowed the research team to gain an in-depth understanding of the spatial characteristics of the two communities involved. The maps allowed the research teams to explore where the children live in relation to schools, churches or health facilities. The children also highlighted households that are important and supportive to them as well as areas of danger (such as crocodiles living by the river) – for an example, see Appendix 8. The historical profiles depicted the children's time-line, from birth to present, and highlighted important life events. These profiles gave the research team a quick overview of when, how long and for whom the children had been caring and the year of death of family members close to the children. The profiles also brought forward the school years they had to repeat and seasons characterised by famine, for an example, see Appendix 9. The daily routine diagrams on the other hand sought to depict their routine on an average day during the week and during the weekend. These diagrams illustrated how many hours the children spent, on average, doing certain activities, for an example, see Appendix 10. These exercises not only provided the research team with a good overview and insight to young caregiving that would facilitate the interviews, but it helped me and the children to see how things relate to each other spatially and over a period of time (Rifkin & Pridmore, 2001). The fourth PLA exercise (which was part of phase two) involved a total of three draw-and-write assignments, covering the themes 'outcomes and benefits from their activities', 'working as part of a team' and 'problems faced in this programme'.

The children were encouraged to make a drawing and write a short story or essay to the themes presented to them (see Appendix 7). Rifkin and Pridmore (2001) argue that drawing pictures can facilitate the breaking of barriers and allow for emotions to be expressed. I have found writing techniques particularly helpful in this context due to the 'culture of silence' characterising children in this area and inhibiting the quality of verbal interviews. The draw-and-write technique was also used during the photovoice exercise for those children who did not capture certain situations (see explanation below).

Photovoice

In another attempt to engage the children as participating researchers, I used photovoice, a methodology developed by Wang and colleagues (Wang & Burris, 1997; Wang & Pies, 2004; Wang et al., 1998). The method involves a process in which people can identify, represent and enhance their community or circumstances through photographic technique (Wang & Burris, 1997). Although photography has been used as a technique for collecting data before (Bateson & Mead, 1942; Dabbs, 1982), it is only recently it has been conceptualised as a method in which marginalised populations can voice their concerns and perspectives. A number of advantages have been identified of using photovoice with children. Punch (2002), for example, notes that children are less likely to be influenced by their friends in photography than in drawing as they cannot look over their shoulders and see what their peers are drawing. Furthermore, taking pictures do not depend of the children's ability, or perception thereof, to make a drawing (Punch, 2002). Having said this, we actively encouraged the children to draw scenarios or situations that they did not capture on camera, either because of the limited time in which they had the cameras (two weeks), or because they felt it was inappropriate or dangerous to take a photo of the situation they wanted to share. The process in which we involved the children in photovoice is elaborated upon in Appendix 11.

The social psychological benefits of photovoice have been documented in different contexts. Gabhainn and Sixsmith (2006), for example, found children as young as 8 years able to participate as researchers of child well-being and Stack and colleagues (2004) in their study of youth, found the technique to develop an awareness of their ability to become positive agents for change within their community. Due to its public nature, photography as a research method is an ethical minefield and has rightfully been subject to much discussion (Fang & Ellwein, 1990; Macintosh, 2006; Wang & Redwood-Jones, 2001). I will return to this debate at the end of this chapter (Section 3.4).

Reflecting my interest to involve the children participating in this study and to provide them with some power and control in the process, I used a variety of participatory methods. The PLA exercises I used, and have described above, have been identified to potentially 1) provide OVC with a recognition of their role as experts in their own communities, 2) foster deep reflections, and 3) create a context safe for exploring diverse perspectives (Foster-Fishman, Nowell, Deacon, Nievar, & McCann, 2005). Nonetheless, these PLA exercises were also complimented with more traditional research methods such as essay writing, individual interviews and group discussions – methods I shall now turn to.

Essay writing

Essay writing has been identified as an effective way of gathering information in children's own words about practices of caring and has been identified as less intimidating than one-to-one interviews (Robson & Ansell, 2000). Robson and Ansell (2000) also found essay writing to be an ethical research tool, allowing children to recount their experiences on their own terms, communicating as much, or as little, as they wanted. Whilst children's written abilities may prove to be a constraint for some children, the multi-method approach adopted in this study, ensured that all children had an opportunity to articulate their experiences in a way they felt most comfortable with. Other constraints to essay writing include instructions given to the children, expectations concerning length and levels of self-revelation as well as the structure of the written composition. Robson and Ansell (2000) argue that these constraints suggest that essays should not be read and understood at face value, but as texts developed in a context.

Essay writing workshops were conducted on two occasions. In phase one, essays were used to explore in-depth individual caring experiences. In a workshop both at Moja and Mbili, the children were asked to write an essay with the title: 'My time as a caregiver'. A total of 27 children from the two communities submitted an essay to the research team, which was from all the children present at the workshop at the time, with the exception of one who had to leave early because of other commitments. In the second phase of the study, the children were asked to write an essay with the theme 'being part of a team'. To guide the structure and content of their essays, the children were provided with three questions. 1) What are your feelings about being part of a team? 2) What, if anything, have you learnt from being part of the team? 3) Why do you think that is? All the children present during the workshop (n=16) submitted an essay. The lengths of the essays varied between one and two A4 sheets of paper. They were written in either Dholuo or English, depending on what the child wanted and felt most comfortable with. Dholuo versions were translated into English by Cellestine.

Individual interviews

One of the most established qualitative research methods is qualitative interviewing (Flick, 2006). According to Silverman (2005), the epistemological position of the researcher impacts on the type of individual interviews being conducted. Positivists are looking for 'facts of life' and place great emphasis on validity and reliability, random sampling and often closed questions. Constructivists focus on the experiences of the individual and draw on unstructured and open-ended interviews (Silverman, 2005). As I mentioned earlier in this chapter, I align myself with the constructivist perspective and my starting point for using interviews is based on the assumption that the social world and the circumstances of young carers are not entirely of their own making, but partly determined and actively constructed by people and organisations in their everyday life (Bauer & Gaskell, 2000). Qualitative interviews therefore have the potential to generate valuable contextual understandings of the variables that impact coping and psychosocial well-being of young carers.

The aim of phase one was to elicit a wide range of opinions and contextual understandings of providing care for an adult, 25 (out of 48) children were purposefully selected for individual

interviews based on their diverse experiences as young carers and their willingness to participate. Historical profiles, daily diagrams and photovoice essays all provided the information required to select children with diverse experiences. Some of the variables considered were age when first caring, gender, repetitive caring, whom they were caring for, duration of caring and support networks. However, most of the children shared similar circumstances and only differed slightly from one another.

The young carer interviews were carried out in Dhluo language by Vincent and Cellestine. The interviews followed a semi-structured topic guide (see Appendix 3) that started off by asking into their daily routine, including what activities they were doing, with whom, where and when. This was followed by questions related to caring and livelihood strategies and attention was paid to age and gender dynamics with regards to expectations and responsibilities. In phase two, 10 children agreed to participate in an interview. As phase two set out to explore the outcome of the CCCT intervention, the semi-structured topic-guide sought to uncover the children's perspectives of the programme, how it was implemented, as well as the opportunities and challenges they were presented with.

Boys were interviewed by Vincent and the girls were interviewed by Cellestine. A total of 35 interviews were conducted with young carers, lasting between 20 and 80 minutes (average 43 minutes), with interview length being generally correlated to age. Interviews with adults followed two sets of topic guides for phase one, one for community members and one for professionals, and a separate topic guide for phase two interviews (see Appendix 3). For both phase one and phase two, 6 adults were interviewed. They were randomly selected from the two communities based on their availability and interest in taking part and all were living with an orphaned and caregiving child. These 12 interviews lasted between 30 and 60 minutes and were conducted by Cellestine and Vincent in Dhluo.

The four 'professionals' were purposefully selected as key-informants. Two of them were living within the communities and acted as chairwomen of the respective community organisations that were active in the two communities. One key informant was the district children's development officer and the other was a social development assistant, who represented the DGSS in the district. All four 'professionals' act as facilitators for NGOs and government departments on issues related to child rights and well-being and therefore provided an invaluable insight to what dilemmas they face as mediators of Western notions of childhood and development and the perspectives active on the ground. These four interviews took between 90 and 120 minutes and were carried out by myself in English.

Group discussions in a workshop setting

Like individual interviews, collecting data in a group is particularly useful for exploring people's knowledge and experiences and can be used to examine not only what people think but how they think and why they think that way (Kitzinger, 1995). Flick (2006) distinguishes between four different

ways of collecting data in a group. I find this particularly helpful in justifying the methods I used to collect group data. Flick (2006) talks about group interviews, group discussions, focus groups and joint narratives. Group interviews refer to an interview with a small group of people on a specific topic. Group discussions reveal the way in which opinions are produced, expressed and exchanged within a context where these occur more naturally than in an isolated interview setting. Additionally, opinions or views that not socially shared or incorrect may well be corrected and serve as a mean to validate views. Group discussions may also provide a tool to which opinions are reconstructed.

Focus groups also generate discussion, but the discussion is highly focused on a theme and aims to generate diversity and difference of perspectives within or between groups. Joint narratives are often used by ethnographers who use this method to elicit discussions and story telling within a setting (e.g. in a household). Overall, the interaction between participants in a group allow for exchanges of ideas and impressions, highlighting meanings and representations in a more genuine social interaction than what individual interviews can facilitate (Gaskell, 2000).

Of the four types of group methods, I decided to use group discussions as it allowed us to bring many people together and explore what some of the more prevailing representations of children and young carers were in Moja and Mbili. A total of four group discussions were conducted, 2 with children and 2 with adults. Adult discussions were facilitated by a local social development facilitator who got the community members to share stories and anecdotes from the community and used these stories to elicit discussion in line with the topic under study. By drawing on local realities, the facilitator drew on the joint narratives approach insofar as he managed to find common reference points that allowed participants to have an opinion or say on the matter. As this study takes place in an area of Kenya where many aid agencies are working, specific focus groups discussions and group interviews, conducted within an artificial setting and focus, may elicit socially desirable answers – in the hope that their responses will increase the flow of aid. For this reason, the research team believed that bringing people together in their natural setting (such as in the local church) to discuss issues in line with this study and facilitated by a local facilitator would be the best way forward in capturing genuine social interaction, representations, meanings and socially dominant views. In collecting the data in a local and natural setting, we also allowed for community members to negotiate and reconstruct opinions and meanings.

The theme of the group discussions with adults was 'orphan care and support issues' and they were attended by a total of 31 adults from the two communities. The workshops were open for all adults within the community and no selection criteria were applied. The participating adults gave consent to the workshops being recorded and used for research purposes. The two group discussions conducted with the young carers were facilitated by Cellestine and Vincent and included 12 and 15 children respectively. There was no selection criteria, all children that showed up for the workshop could participate. The discussion and dialogue was centred on their experiences of caring.

Field notes

Cellestine, Vincent and myself kept a logbook in which we recorded activities, reflections and thoughts about the interviews and workshops that we attended and facilitated throughout the study (see Appendix 12 on guidance of field note taking). Reflections on conversations that Cellestine and Vincent had with the children during club days were also written in the field notebooks (see Appendix 14 for an example). Aside from triangulating findings and emerging themes from the data the field notes also had a more practical purpose, namely documenting the process of approaching the field, experiences and difficulties faced – something Flick (2006) argues is crucial if more than one researcher is involved.

Table 10: Data collection procedure

Phase	Steps	Date	Who	N	Methods	Sampling
1	1	May/June 2007	Young carers	48	Daily diagrams, Community maps and history profiles	Recruited purposively through local community guides
	2	July 2007	Young carers	48	Photovoice and draw-and-write technique	Recruited purposively through local community guides
	3	July 2007	Young carers	27	Essay on caregiving	All participating children invited
	4	July/Aug. 2007	Young carers	24	In-depth interviews	Selected to represent diversity of responses on photovoice and willingness to participate
	5	Sept./Oct. 2007	Young carers	33	Group Discussions	All participating children invited
	6	Sept./Oct. 2007	Adults	10	In-depth interviews	Purposively to include lay people and social development professionals
	7	Nov. 2007	Adults	31	Group Discussions (n=2)	A public notice invited all adults in the community
2	8	April 2008	Young carers	16	Team work essays	All participating children invited
	9	Nov. 2008	Young carers	21	Draw-and-write essays	All participating children invited
	10	Nov. 2008	Young carers	10	In-depth interviews	All participating children invited
	11	Dec. 2008	Adults	6	In-depth interviews	Recruited purposively, based on their relationship with children active in the programme
	12	Feb. 2009	Investigators	3	Field diaries, project reports and proposals	All investigators involved in the study

Table 11: Young carer participants

	Pseudonym	Sex	Age	Orphan status	Phase 1					Phase 2			Status in project	
					Historical timeline	Daily diagram	Photo voice	Caring essays	Interviews	Group discussion	Team work essays	Draw-and-write essays		Interviews
Moja	Arthur	M	15	Single	x	x	x	x		x				Drop out*
	William	M	14	Single	x	x	x							Drop out
	Samuel	M	13	Single	x	x	x	x	x	x	x			Active
	Jackline	F	14	Single	x	x	x				x	x	x	Active
	Jael	F	14	Single	x	x	x	x	x		x			Active
	Austine	F	14	Social	x	x	x	x			x	x		Active
	Mark	M	13	Double	x	x	x	x	x		x	x		Active
	Loyce	F	14	Double	x	x	x							Drop out
	Catherine	F	14	Double	x	x	x	x	x					Drop out
	Lydia	F	14	Single	x	x	x	x	x					Drop out
	Linnet	F	13	Single	x	x	x							Drop out
	Josephine	F	16	Double	x	x	x							Active
	Philip	M	12	Single	x	x	x	x	x					Active
	Florance	F	15	Double	x	x	x	x	x	x	x			Active
	Debora	F	15	Single	x	x	x			x	x	x	x	Active
	Salome	F	13	Single	x	x	x			x		x		Active
	Paddy	M	15	Social	x	x	x	x						Active
	Edith	F	17	Single	x	x	x	x	x					Drop out
	Pascal	M	14	Single	x	x	x	x	x	x	x	x	x	Active
	Pius	M	16	Single	x	x	x							Drop out
Zeddy	M	16	Single	x	x	x	x	x	x	x	x	x	Active	
Susan	F	13	Single	x	x	x		x		x	x		Active	
Mildren	F	15	Single	x	x	x							Drop out	
Rebecca	F	14	Single	x	x	x			x	x	x	x	Active	
Fanuel	M	17	Double	x	x	x	x	x	x	x			Drop out	
Beryl	F	14	Double	x	x	x	x	x	x	x	x	x	Active	
Ben	M	15	Social	x	x	x							Drop out	
John	M	12	Double	x	x	x	x	x	x		x	x	Active	
Benard	M	12	Double	x	x	x							Drop out	
Mary	F	15	Single	x	x	x	x		x				Drop out	
Mercy	M	12	Double	x	x	x	x	x					Active	
Geoffrey	M	13	Double	x	x	x			x		x		Active	
Kevin	M	12	Single	x	x	x			x	x	x	x	Active	
Lucy	F	12	Single	x	x	x				x	x		Active	
Carolyne	F	15	Double	x	x	x	x	x		x	x	x	Active	
Michael	M	15	Social	x	x	x	x	x	x	x			Active	
Jane	F	17	Social	x	x	x	x	x			x		Active	
Joyce	F	12	Social	x	x	x		x			x	x	Active	
Millicent	F	15	Single	x	x	x	x						Drop out	
Syprose	F	14	Social	x	x	x		x					Active	
Rael	F	12	Social	x	x	x							Drop out	
Vincent	M	12	Single	x	x	x							Drop out	
Sharon	M	15	Double	x	x	x							Drop out	
Janet	F	15	Double	x	x	x	x	x	x				Drop out	
Everline	F	14	Single	x	x	x	x	x	x		x		Active	
Roseline	F	14	Single	x	x	x	x	x					Active	
Carren	F	17	Social	x		x	x	x					Drop out	
Francis	M	14	Single				x	x		x	x		Active	
TOTAL					49	48	48	27	25	2	16	21	10	

* Reasons for drop out are discussed in Chapter seven

3.3 Data analysis and interpretation

Following a detailed description of how the data were collected, I now proceed with an account of how the data were prepared for interpretation. I do so by first explaining the process in which the data were prepared for analysis and then give a transparent account of how I categorised and coded the data set. This will be followed by a description of how I analysed and present the findings using Attride-Stirling's (2001) thematic network analysis.

3.3.1 Data preparation

All verbal data were recorded using an Olympus VN-960PC digital voice recorder. Cellestine transcribed all the interviews into Dhluo language and random quality checks were carried out to ensure exact and accurate transcription. Due to the complex structure and cultural meanings attached to Dhluo language, translation from Dhluo to English turned out to be a time-consuming process with on-going debate and consultation amongst all three investigators regarding the best way to translate certain phrases and words. Two random translations were back-translated into Dhluo language to compare accuracy and reliability of the translations. No major discrepancies were found. Translations were then typed into a rich text file in a transcript format (a primary document). Written data were also translated and typed into a transcript format. For examples of transcripts, see Appendix 13 and for an example of field notes, see Appendix 14. The study generated a total of 162 primary documents amounting to nearly 200 000 words of data, or approximately 400 pages of 1.5 line spaced transcripts. Interview files and photos have been stored on password protected CD-Rom's and transcription notebooks, field notes and the original essays have been locked away in a secure location.

3.3.2 Thematic network analysis

Interviews, group discussions and written narratives were coded and analysed in Atlas.Ti using thematic networks analysis (Attride-Stirling, 2001) over two phases. Attride-Stirling outlines six stages for interrogating explicit statements made by research informants to uncover implicit social meanings and coping strategies, stages that I followed for both phase one and phase two of this study. I discuss each of these stages below by illustrating the procedure in relation to my coding framework and thematic networks.

Categorisation and coding (step 1)

The first stage of the analysis involved my familiarisation with the data set by reading and re-reading the transcripts. Vincent and I sat down and discussed the core themes that emerged and individually began categorising the text using coloured pens and each of us developed a rough coding framework. We compared our initial coding framework and discussed disagreements and discrepancies, eventually agreeing on an initial coding framework.

To get an overview of the large body of data, all primary documents were transferred into Atlas.Ti in order to dissect the data into text segments using the coding framework. This data set is referred to as a 'hermeneutic unit'. The coding (labelling of text segments/quotes) of written narratives or interview transcripts of young carers was done with reference to the relevant daily diaries, historical profiles and field notes on the individual child, providing a more accurate and in-depth understanding of the code attached to the data. Using the coding framework, each of the 162 text files (116 from phase one and 46 from phase two) that make up the entire data corpus were segmented in Atlas.Ti (for an example of coding in Atlas.Ti, please refer to Appendix 19). This provided a clear overview of the codes. Text segments (quotes) from each of the codes were then re-read. This was important as the meaning of some of the codes changed slightly as my coding progressed. This also meant that some codes split into two similar, yet different codes and a few quotes had to be moved into another code. The coding framework was developed on the basis of my theoretical interests (social psychology of coping) and on the basis of salient issues that arose from the data itself (positive and negative experiences, challenges and successes, benefits and limitations). These two dimensions of analysis and foci enabled me to go through the entire data set and identify the important issues that would address my research questions (see Section 1.6).

Let me give a couple of examples of codes and their content. The code 'helpers' included quotations such as "a child is called a helper because when a parent or guardian want something which he or she is unable to go and get, they will send the child to go and get it" and the code 'community support' had quotations such as "this photo reminds me of the kind of support and love we get from the community members. If I need anything, I tell them and if it is available, I will get it." An area of text could be classified under more than one code.

Identification of themes (step 2)

A total of 121 codes make up the coding framework (see Appendix 15). Once all the text had been coded, the text segments (quotes) that belong to each code (or group of related codes) were re-read and emerging themes that seemed significant and salient to this study were abstracted. As illustrated by the coding framework, the 121 codes were grouped into clusters. I made notes of the issues that were being discussed under each code, their prevalence and contradictions, and highlighted quotations that encapsulated the issues well. The codes contained over 1,200 quotations and were reduced to 78 basic themes (listed in the third column of Appendix 15). To limit the number of themes and to report on themes that characterise young carers as a group, commonalities were given priority. However, text segments that highlight differences and contradictions within a theme will also be identified and discussed when describing the data.

Constructing the networks (step 3)

The next step of the analysis involved networking and organising these basic themes into organising themes (secondary). To do this, the basic themes were clustered into larger and shared issues (referred to as organising themes) that were named according to the content underlying them. A total of 22 organising themes were identified to represent the basic themes (see column

four, Appendix 15). A similar process was followed for the organising themes which were clustered together into global themes that encapsulate the main content of the data set.

The majority of these groupings were derived on the basis of their content, but some themes were grouped together on more theoretical grounds (e.g. 'loss or damage' and 'strategic caregiving'). These clusters of basic themes were then brought together under a large and shared title. Charcoal burning⁶, domestic work, farming and poultry keeping and the like highlight ways in which young carers cope through income generating activities and were therefore rearranged into an organising theme of that title. This organising theme and others that are related (see Appendix 15) all contain some assertions, propositions or assumptions of an underlying argument, which is encapsulated by the global theme.

This network analysis was first done in Atlas.Ti via 'network view manager' which allowed for a visualisation of the networks and further refining of the themes presented. The themes were then transferred into tables, each representing a global theme and which will be introduced in the beginning of each chapter.

Exploring and interpreting the thematic networks (steps 4, 5 and 6)

The remaining three steps of Attride-stirling's thematic network analysis take place during the presentation of findings and the conclusion. Having mapped the thematic networks, and the associated organising themes, I returned to the original data to refine my understanding of the issues at hand and to re-examine the data in the light of this emerging framework of analysis. This re-examination and exploration of thematic networks materialised in the chapter's four to seven. In these finding chapters I describe the content of the thematic networks and explore underlying patterns, differences and commonalities with regards to gender, location, caring arrangements and age groups (12-14 and 15-17) (step 4). I conclude each findings chapter with a brief summary of the thematic network and findings that arose (step 5) and relate these findings and interpretations to my research questions and objectives in Chapter eight, the concluding chapter (step 6).

3.3.3 Generalisability

Most social scientists aim to make some general statements that can be extended beyond their particular set of observations (Gaskell & Bauer, 2000). At what stage can one confidently make generalisations about research findings? The answer is generally found in representative sampling and sample size. However, qualitative research, often looking at small scale cases that have been sampled to highlight something new and different, cannot speak of generality in the same way as survey type research. To this end, Cornish (2004) has highlighted three responses towards

⁶ Charcoal burning is an activity done by many children to generate income. The activity involves fetching of fire wood and the extraction of water and oxygen from the wood through heating and slow burning. The outcome is coal which can be used for cooking and is widely sold in rural market places.

generalisability in qualitative research: 1) human judgement, 2) a typical case and 3) the theoretical case – each of which I will now discuss.

The first, and perhaps overarching, response to the problem of generality in qualitative research is that of *human judgement*. Flyvbjerg (2001) for example argues that the social sciences should move away from trying to produce generalised and context-free conclusions, and instead rely on 'human judgement' to decide whether the study findings of one context can be applied to another context and thus be generalised. Such an approach relies on the interpretative skills and experience of social researchers and is based on the supposition that social scientists build up an expertise and in-depth understanding of small scale and qualitative studies from reading, encountering and dealing with the concrete and detailed particulars of these studies (Flyvbjerg, 2001; Lincoln & Guba, 1985). Social scientists will therefore become experts and draw on their knowledge from studying many small scale qualitative studies to decide, using their judgement, whether the findings of one qualitative study can have implications for another in a different context. Gaskell and Bauer (2000) as well as Lincoln and Guba (1985) argue that 'thick description' of the phenomenon under study is crucial to provide an optimal base for the inquirer to make an informed judgement about the generality of the phenomenon. To facilitate the judgement of the reader of this thesis, the first finding chapter (Chapter 4) will provide a detailed insight to the cultural context of the caregiving children participating in this study. In addition, all finding chapters will use plenty of verbatim quotes to facilitate this 'human judgement'. To use this 'human judgement' the inquirer will be drawing on past, present and future work to decide whether my findings can be generalised and transferred to another context. Cornish (2004:97) argues that "deferring the establishment of generality until somebody uses that finding to make sense of a new context is an important pragmatist step to thinking differently about the proof of generality". In other words, the generalisability of this study can only be confirmed with the application of the theoretical work in another context, or if done by another researcher.

A second response to the generality of qualitative research is that of the *typical case or phenomena*. In choosing a representative or typical case to study, one draws on the same logic that survey type researchers use when a random sampling is used to generate data that is representative of the population (Cornish 2004). In choosing to study a typical case one would identify a series of key variables (such as cultural practices, socio-economic status of the location, the size of the location, rural and urban characteristics and so on) to assess the representativeness of a case (Seale, 1999). Similarly, if another study declares similar variables, the expectation is that the findings should be transferable to that other case (Cornish, 2004). It is therefore important to declare the cultural context (as done in the Introduction and in Chapter four) of the study as this will facilitate the 'human judgement' of whether this is a typical case or not and to what cases it can be compared. Cornish (2004) highlight the difficulty of defining which variables are the most important ones and argues that this decision is a theoretical one and different theories will suggest different core values. Another problem with choosing a 'typical case or phenomena' to study is that it may just reflect the typical state of affairs and is thus less likely to engage in critical theory. If a

researcher decides to study an unusual case, he or she is more likely to identify pointers towards social change.

A third approach towards generality is called *theoretical generalisation*. In this approach generality is achieved through researchers drawing on theoretical concepts that can be applied in a variety of contexts (Walton, 1992). As was the case of my study, Bondo and young caregiving, representing the cultural and geographical context and phenomenon, were not chosen because they were typical of an East African population, but because they were interesting in relation to a number of theories (coping, resilience, children as social actors, OCC). As starting assumption of this study was that young carers coped with difficult circumstances through their participation in community life and thus opened up for an inquiry into some of the social psychological processes that facilitate their coping – identifying strategies which might (but not necessarily) also apply to other children in difficult circumstances elsewhere in Africa. As I began to conceptualise some of the key coping strategies of young carers it became a case of interpreting my data and integrating theory. Returning to the issue of future studies and generality, Seale (1999) suggests that this kind of qualitative case work should be referred to as ‘generating theory’ as opposed to ‘generalising to theory’ – again because generality is not demonstrated within the study, but is an outcome of future research that follows, drawing on a similar theoretical framework. Cornish (2004) outlines the importance of theoretical frameworks, arguing that small scale and exploratory studies that engage with common theories used by a community of scientists, are not merely single cases, but form part of a larger set of observations and conceptual work that contribute to the development of theoretical frameworks. As much as qualitative research can support theoretical and conceptual frameworks, they can also challenge general theories. So, by choosing an unlikely or surprising case, a theory can either be falsified or gain stronger support. For example, if much of the expanding literature on young carers in Africa focuses on their needs and problems, compounded by a commitment to children’s rights and dominant understandings of childhood, this study, highlighting their coping strategies and local context, challenges some of the existing theoretical frameworks used to study young carers in Africa.

By attaching my findings to the theories outlined in the previous chapter, I have made an attempt to facilitate the generalisability of my research. However, as the above discussion has outlined, the achievement of generality will only take place when my interpretations and conclusions prove useful in another context. As the same applies to similar studies carried out previously to mine and that applied similar theories, my findings can either support or contrast the generality of these studies. As stated by Cornish (2004) qualitative research contributes to the generality of the empirical and theoretical studies on which it draws and contribute to a new set of knowledge that can be taken up and used, eventually achieving generalisability. I will return to the issue of generalisability in my concluding Chapter.

3.4 Ethical considerations and social dilemmas

Ethical research should pertain to do good and avoid harm (Orb, Eisenhauer, & Wynaden, 2000; Young & Barrett, 2001). As I have said earlier, when undertaking research with children one enters a minefield of ethical and social dilemmas. Numerous helpful guidelines, reflecting on the experiences of researchers working with children, have been written to navigate through these dilemmas (see Matthews et al., 1998; Morrow & Richards, 1996; Young & Barrett, 2001). As the lead researcher, I read through this literature carefully, and it provided me with valuable clues to some of the many ethical dilemmas of doing research with vulnerable children in Africa, which informed the planning and conduct of this study.

Formally, given my affiliation with the Institute of Social Psychology, the study's institutional requirement was to follow the ethical guidelines outlined by the British Psychological Society (cf. BPS, 2004). Ethical clearance was granted by the Research Ethics Committees of the London School of Economics and permission to conduct the study was granted by the Department of Gender and Social Services in Kenya (see Appendix 16 for permission letters). The forthcoming section goes into detail with some of the more pertinent ethical issues related to this study.

3.4.1 Doing research with young carers

Verbalising and articulating the loss of a parent, or describing the anguish and pain experienced by a loved one is without question a difficult task for anyone. This is no different for young carers, many of whom have experienced both bereavement and provided palliative care (Martin, 2006). Reporting on some of the dilemmas faced whilst doing research with young carers in Zimbabwe, Robson (2001) found almost half of her informants to be unwilling or unable to complete the interviews as they were in tears. Some of the interviews came too soon after bereavement and were 'adding salt to a raw wound' (Robson, 2001). Robson's (2001) own interviewer called the interviews 'unfair', 'cruel' and 'uncalled for' and in conflict with her role as a social worker as she felt the interviews were traumatic and stressful for the children. Robson (2001) noted that the children's unwillingness to continue was a sign of agency in an otherwise subordinate research encounter and she believes that distress experienced by the children may be justifiable in order to listen to their voices, bring benefits to young carers in the future and to challenge conceptions of children as non-working dependants. The experiences of Robson suggested that I had to think very carefully about how we, as a research team, intended to gather information about the lives of young carers in Kenya.

Based on Robson's experiences the research team wanted to minimise the distress experienced during data collection and build rapport and break down power structures in the research encounter as children in this area are characterised by subordination and a 'culture of silence'. This would allow for the children to freely say that they no longer wished to continue with the interview or PLA exercise. Likewise, it meant that local investigators should be aware of the fact that some children might find the data collection distressing and may not voice their unwillingness to participate.

Several measures were in place to minimise the potential distress. One of the uses of the history profiles was to identify the year or month of death of loved ones and to ensure we gave those children the time and space to heal, a time period negotiated with the children concerned. Written narratives were also my preferred and primary method of data collection as this would allow the children to reflect, and possibly cry, in their own space without an investigator waiting for their responses. The written narratives also gave the children the space to pick and choose what they were ready to share with us.

It was important for us to have a good rapport between the children and the local investigators. Over the two years the data collection took place, the investigators also acted as social workers, visiting the homes of the children, attending funerals and providing moral support. It may be argued that the blurring of Vincent's and Cestelle's roles as both a researcher and a social worker presents another ethical dilemma. However, I believe that the unique circumstances of young carers justify this dual role and we trust the children to have the competence to manage this relationship.

Through this approach we believe that we minimised the distress to children by creating as non-alienating a data collection context as possible. Over the two year period in which this study was conducted, only one child cried during data collection. The interview was immediately brought to an end and the girl spent five minutes with the research assistant who was giving her comfort before she returned to play volleyball with her friends. She was subsequently encouraged to write down any further stories she wanted to share with us and the research assistants paid the girl a couple of informal visits to ensure she was doing alright.

I believe that much of the distress facing Robson's children was due to the timing of their interviews, and to the fact that the children may have felt uncomfortable in the one to one interviews with a researcher that they do not know very well. Some of Robson's children may not have been emotionally prepared for the sudden questioning of parental bereavement, whereas the children participating in this study had been sensitised and slowly accustomed (using a variety of methods over a longer period of time) to think of their experiences of parental care and bereavement in a supportive environment and therefore not caught off guard during interviews. As a research team we believe that this method reduced the levels of distress experienced by the children and therefore serve as a good example for people who want to do research with children who may have experienced distress and parental bereavement, avoiding the kind of scenario experienced by Robson (2001).

Although it has been argued that the focus on ethical issues within child research literature is largely due to the construction of children as vulnerable and incompetent (Kirk, 2007; Valentine, 1999), we still believe that young carers require particular ethical considerations, partly because of the sensitivity of the topic under investigation, but largely because of the unequal power relations that exist between adults and children.

3.4.2 Working within power structures

The hegemonic adult centeredness of society is often allegedly duplicated in research involving children, with little real involvement of children or their disenfranchised position (Kirk, 2007; Morrow & Richards, 1996; Punch, 2002). As said earlier, this raises the issue of how much freedom children have in choosing whether or not to participate in a study. As Christensen (2004) points out, we must question how different degrees of power can affect participation, and in turn, how this might affect the knowledge derived from the research. A number of examples can be identified. For example, in both communities, children were accessed using 'gatekeepers', adults who may refuse one child and put pressure on another to participate. Implicit or explicit expectations by community leaders, school leaders or parents, may also lead to the inclusion or exclusion of particular children, as well as limiting the freedom of children to refuse to participate if they so wish. Although the two local field investigators were young, they may still have been perceived as adults by some of the younger children which could affect their responses. The fact the investigators were also representatives of a local NGO may also have contributed to response bias. Research into social desirability responding (SDR), which refers to informants' attempts to shape their answers purposefully to mirror a more socially desirable image (Paulhus, 1991), is still lacking in the context of participatory action research projects and research with NGOs. SDR, or impression management, generally refers to respondents' desire to come across positively and therefore avoid giving information that reflects on them badly (ibid.). However, in a poor resource setting, with investigators representing an NGO, the reverse may happen. In an attempt to access resources and support via the NGO, informants may provide answers that exaggerate their vulnerabilities, a potential limitation of this project.

In accordance with Kirk (2007) we addressed the power differentials between adults and children by using a myriad of participatory research methods that gave the children the maximum opportunity to provide their views. They were involved as researchers through photovoice and other PLA exercises and we were conscious about the children's rights throughout the process. We continually checked-up on their willingness to participate and reiterated their right to decline participating at any time. We also showed the children how to switch off the voice recorder, so they felt they had some control over the recording. From the onset of the youth clubs and the research project, Vincent and Cellestine told the children that they had the power to make a difference and that sharing with us their experiences were the most important aspects of the project. It was made clear to the children that they were the experts and we were merely here to learn from them and join them in their journey.

3.4.3 Informed consent and confidentiality

The Nuremberg code, drafted by a tribunal after harmful research experiments during the second World War, has had a significant impact on how normative informed consent is used today (Haggerty, 2004). Informed consent implies that research participants are given the necessary

information to weigh up the risks and benefits involved with their participation (Williamson, Kent, & Ashcroft, 2005). We required all children and their guardians to sign a consent form (see Appendix 17) and placed great emphasis on ensuring that the participants fully understood the purpose with the consent forms. Although we believed the children to be competent enough to give their own consent, the need for consent from guardians of children below the age of 18 is generally agreed to be good practice. We used three types of consent forms. All children involved in the project signed a consent form which explained the purpose and their role in participating in this research project. This form was complimented with a consent form addressed to their guardians. The third and final consent form was addressed to the children involved in the photography exercise on their understanding of the ethical implications of taking photos and giving us the right to use their photos.

As the informants and field investigators are likely to hold different understandings of ethics, research or consent it can be argued that all the protocols and procedures adopted are more about safeguarding the researchers than the children (Fang & Ellwein, 1990). While rigid protocols can ensure responsible research, it does suggest that the children may not fully understand what they are consenting to. With this awareness, much time was spent in preparation of the photovoice exercise, on explaining to the children the importance of getting consent from those on the picture. Nevertheless, as this is very much a Western research requirement and perspective, it was difficult for many of the children to really grasp the purpose of consent in this context.

Another issue that may have biased the giving of consent in this study was the intervention. Although the children were unaware of the size of support coming their way, the involvement of an NGO and social workers may have hinted to the benefits that were to be had from their participation. Although this may positively suggest that the benefits outweigh the 'risks', an ethical observation we have made is that these compelling benefits may overshadow their wish to take part in this study. Influenced by the desire to benefit, some children may not have felt that free to refuse to participate.

As we ensured confidentiality, pseudonyms have been used to protect the identity of the two participating communities and the participants. However, because of the public nature of photographs, it was difficult to completely conceal the identity of the setting and the participants (Fang & Ellwein, 1990). To avoid inappropriate misplacement of their photos, all the photos taken by the children, with exception of five scanned versions of the photos they selected to write about, were returned to the children. The faces of those appearing on the photos in this thesis have been blurred.

In line with the aims and objectives of this study, we treated the children as competent and active agents and we hope that this may have circumvented some of the potential power structures. Nevertheless, according to Mayall (1994) the power differentials between adults and children are less significant in the data collection and it is in the interpretation and write-up stage where power structures really operate. Similar warnings have been made by Qvortrup (1994) and I hope that by representing young carers as active agents I am using my power as a researcher in a positive way.

Conclusion

This chapter has outlined the procedures used in the research, and some of the difficulties and challenges in doing research with children in a poor resource setting. Background to participatory action research and the involvement of children's perspectives situated this project firmly within community health psychology and provided the necessary setting to present the methodologies used. Detailed accounts of sampling, data collection and analysis, provided a transparent overview the procedures involved in this study, making the study replicable in another setting. The chapter finished off with some of the ethical considerations and social dilemmas that may be encountered during the study. Against this background the next part of this thesis presents the findings of this study.

Part B - Study findings

Part A of this thesis provided the background and rationale to this study. It placed the study within a personal and intellectual context and provided a transparent account of how data were collected and processed. This second part of the thesis will present the findings of this study. Findings will be presented in four chapters, each of which is inspired by one or more thematic networks derived from the data. The six thematic networks developed from the data are:

- 1) Dynamics and characteristics of children's lifeworlds
- 2) The circumstances and perceptions surrounding young carers
- 3) Challenges faced by young carers
- 4) The social coping strategies of young carers
- 5) The psychological coping strategies of young carers
- 6) Process and impact of CCCT

Table 12 outlines the networks that will be described in respective chapters and links these to the research questions developed in Chapter one.

Table 12: Chapters overview

	Chapter four: The multiplicity of children's lifeworlds	Chapter five: The social coping strategies of young carers	Chapter six: The psychological coping strategies of young carers	Chapter seven: A psychosocial intervention for young carers
Thematic Network	1. Dynamics and characteristics of lifeworlds 2. The circumstances and perceptions surrounding young carers 3. Challenges faced by young carers	4. Social coping strategies	5. Psychological coping strategies	6. Process and impact of CCCT
Research Question	What is the nature of their caring roles and responsibilities? What are the psychosocial needs of young carers in Western Kenya?	What coping strategies have they developed to deal with their challenging social circumstances? What factors facilitate and/or hinder coping?		What role can community-based capital cash transfer play in strengthening the orphan's ability to cope?
	What is the most feasible way of providing psychosocial support to 'young carers' in Africa? How can support agencies best work to reinforced existing and latent coping skills?			

Early on in my finding chapters (4-7), I present the thematic networks in a table format. These tables not only demonstrate how my codes and emerging themes from the data evolved into a bigger network of themes, but they also illustrate the structure of the chapters. For example, Chapter five represents the global theme of one thematic network (social coping strategies). The four sections discussed in the chapter, each represent an organising theme of the thematic network, which in return discusses some of the basic themes and issues that emerged from the data. My hope is that these tables can provide some clarity and justification to my discussion of findings. To support the thematic networks, I make extensive use of verbatim reporting from my sources. These quotes aim to present and capture the essence of the meanings and arguments that emerge from my findings. The quotes therefore differ in size. To contextualise the quotes, they are each followed by an identifier of source; location and method (see Table 13).

Table 13: Participant identifier with explanation

Participant Identifier	Explanation
Syprose/Vincent	Pseudonym names, indicating gender of young carer
Adults	Refers to adults from the community
SDP	Social development professionals
Syprose, 14	Age of young caregiver at time of data collection
Moja	Pseudonym for community 1
Mbili	Pseudonym for community 2
Example of child identifier	Name, age (community/research method)
Example of adult identifier	Adult or SDP (community/research method)

Chapter 4 - The multiplicity of children's lifeworlds

Introduction and chapter overview

This chapter maps out the symbolic universe in which young carers are located and which inform the possibilities and limitations on children's coping which are discussed in later chapters. One aim of this qualitative study is to map out the diverse experiences and understandings of lifeworlds as articulated by a group of young carers. In the process, areas of difference or contrast that provide the possibilities of resilience, coping and of more productive and positive ways of viewing their situation will be outlined. By exploring the multiplicity of children's lifeworlds, this chapter will investigate the socioeconomic and social psychological resources that frame a child's capacity to participate in the life of the community in which s/he is located. To do so, a focus on adult-children relations and notions of childhood will help us understand some of the nuanced and complex circumstances that characterise the participation of young carers and the support available to them through their social fabric.

For an appreciation of the varied circumstances that characterise young carers, findings presented in this chapter should be viewed with an understanding of the ecological diagram (see Figure 3, page 76) presented in Chapter two. Wherever possible, references will be made to the four horizontal principles (interdependence, cycling of resources, adaptation and succession) that trickle between ecological levels, illustrating how ecological levels interact and impact on the lifeworlds of young carers. In order to contextualise these processes (interaction between young carers and their ecological environment) within a coping framework, this chapter reports specifically on the diverse caring circumstances, responsibilities and difficulties which young carers are facing. To do this, three of my six thematic networks will be described and explored in this chapter. These are:

- i. Dynamics and characteristics of children's lifeworlds (see Table 14)
- ii. The circumstances and perceptions surrounding young carers (see Table 15)
- iii. Challenges faced by young carers (see Table 16)

In elaborating on these three thematic networks, I also hope to provide empirical evidence for a more nuanced and accurate conceptualisation of orphaned and caregiving children. Through these illustrations I hope to cover two guiding research questions:

- i. What is the nature of their caring roles and responsibilities? In what ways do they enable and in what ways do they limit the well-being of the caregivers?
- ii. What are the psychosocial needs of young carers in Western Kenya?

Table 14: Global theme: Dynamics and characteristics of children's lifeworlds

Organising themes	Basic themes identified	Issues discussed	Codes
'other' childhoods – different perceptions of childhood (discussed in Section 4.1.1)	1. Adults have an expectation of children to help out sustaining the household. They are seen as an asset.	<ul style="list-style-type: none"> • Child is a gift • Duties fit their abilities • Hard and collective work necessary to combat poverty 	<ul style="list-style-type: none"> - Expected to help out at home (5 children, 6 adults) - Developmental stages (1 child, 27 adults) - Value of children (3 children, 4 adults)
	2. The transition from childhood to adulthood has changed.	<ul style="list-style-type: none"> • Education of children • AIDS and other diseases • Influx of NGOs • Respect of elderly • Sexuality 	<ul style="list-style-type: none"> - Changes to Luo society and childhood (27 adults) - Transition to adulthood (2 children, 22 adults)
	3. Disease and poverty has meant that gender roles are increasingly fluid.	<ul style="list-style-type: none"> • First born child • Boys doing 'girl duties' • Girls doing 'boy duties' • Poverty and gender 	<ul style="list-style-type: none"> - Gender roles changed (1 child, 8 adults)
Relationships between children and adults (discussed in Section 4.1.2)	4. Parents and guardians have the responsibility of ensuring the children become responsible citizens and have access to their basic needs.	<ul style="list-style-type: none"> • Sexual health information • Meet the child's needs • Discipline • Fathers are breadwinners 	<ul style="list-style-type: none"> - Parent responsibilities (1 child, 11 adults) - Role of father (7 children) - Role of guardians (7 children, 5 adults)
	5. A good child is obedient and helps out at home.	<ul style="list-style-type: none"> • Do what is told • Orphaned children are hard working 	<ul style="list-style-type: none"> - Obedience (1 child, 4 adults)
	6. orphaned children are grateful for their guardians and show deep respect	<ul style="list-style-type: none"> • Guardianship is valuable • Children know their disenfranchised situation 	<ul style="list-style-type: none"> - Respect for guardians (7 children, 4 adults)
	7. children aim to please their guardians to avoid disappointing them.	<ul style="list-style-type: none"> • Pleasing guardians 	
	8. Young carers and their cared for help each other through mutual care, love and support.	<ul style="list-style-type: none"> • Reciprocity • Relationship • That's what family does 	<ul style="list-style-type: none"> - Love for guardian (12 children) - Love for parents (6 children) - Mutual care and support (23 children)
	9. Education and modernity has transformed adult/child relationships.	<ul style="list-style-type: none"> • NGO Trainings • Children's department • Lack of respect • Lack of collective responsibility • Generational dialogue 	<ul style="list-style-type: none"> - Child rights (22 adults) - Lack of advice by elderly (6 adults)
The emergence of OVC (discussed in Section 4.1.3)	10. There have been changes to the notion of orphanhood.	<ul style="list-style-type: none"> • No longer a child of the community 	<ul style="list-style-type: none"> - Orphanhood (9 children, 21adults)
	11. Social and cultural changes have increased the vulnerability of children.	<ul style="list-style-type: none"> • Modernity • Increase in orphaned children 	
	12. Orphanhood is associated with abuse and discrimination.	<ul style="list-style-type: none"> • Stepmothers • Violence • Discrimination of orphaned versus non-orphaned children 	<ul style="list-style-type: none"> - Abuse and vulnerability (5 children, 8 adults) - Neglect (2 children, 1 adult)

4.1 Dynamics and characteristics of children's lifeworlds

There are a number of characteristics of Luo society that impact the caring experiences of children. These external forces contextualise their caring experiences and help the children make sense of their circumstances. To fully understand the caring experiences of children, an understanding of their social environment is necessary. I will primarily explore the social environment through local conceptions of childhood, as this will allow me to explore childhood representations, expectations and relationships, all of which enriches our understanding of the nature of their caring roles and responsibilities.

4.1.1 'Other childhoods' – changes and diverse conceptions

In this subsection I explore basic themes 1-3 of Table 14 and look at the representations of childhood that emerged from my interviews with adults and social development professionals. Here I have two aims: Firstly to highlight the way in which local people understand childhood, and secondly to explore the different ecological factors that contribute to changes and new conceptions of childhood. In doing so, I hope to illustrate the tension that exists between traditional Dhluo notions of childhood and contemporary understandings of childhood, some of which reflect Western conceptualisations of childhood (as discussed in Chapter one). This is not to say that notions of childhood are static and binary (Western vs. local, contemporary vs traditional), but is used to exemplify the vibrant and changing nature of local understandings of childhood, and how these understandings are influenced by disease, poverty and Western notions of childhood.

One of the characteristics of local conceptions of childhood that is in stark contrast to Western conceptualisations relates to children's contribution to the household economy, both through income generation and through their participation in home duties, henceforth referred to as children's work. Luo children's working role is part of every day life and language. Children are socialised from a very young age to take an active role in sustaining the household in which they live, something which can be exemplified by looking at different stages of a Luo child's life.

Although there is a general consensus that children's work plays a key role in the practical and economic survival of households and communities, children under the age of 5 years are not expected do heavy duties. Nevertheless, there was a general consensus amongst adult community members that at the age of 5, the socialisation of children to become competent adults should start, preparing them for their roles and duties in the years to come.

“You can tell a 5-year-old to wash a plate because she should be trained in how to do it. She can be told to fetch firewood just to train her. Even when you go to the garden, the child follows you that is how you train a child.” Female Adult6 (Mbili/interview)

Socialisation of children is a good example of the principle of succession in my ecological framework. Based on a historical, and largely continuing, context of subsistence farming and livelihood it is crucial for parents to raise their children with a consideration of future challenges and

roles. It is for that reason some adult informants believed a 5-year-old should start practicing making food for him or herself, but stressed that a 5-year-old should not be expected to cook for the entire household. Aside from reflecting a succession, the socialisation of 'working children' also reflects an adaptation to current problems of disease and poverty, with an increased likelihood that children will be left at an earlier age to fend for themselves due to death caused by AIDS and other tropical disease. Nevertheless, not all adult informants articulated these expectations of a 5-year-old. A minority of adult informants drew on more contemporary and conflicting expectations of 5-year-olds and said that children of this age should be cared for, be in nursery and prepare for going to school.

"A 5-year-old is not strong enough to do anything; he/she is someone that should be cared for and be in nursery, learning the importance of education." Female Adult5 (Moja/interview)

Such a view suggests the influence of more contemporary notions of childhood resulting from the increased availability of educational establishments and Kenyan media and social development professionals advocating 'education for all'. The adaptation, and capacity, to 'accept working children' or 'reject working children' very much depends on the socioeconomic status of the household in question. As one adult from Mbili argues, immediate poverty can only be dealt with through hard work: "when you don't work hard, you will not get anything to eat. A lazy person remains poor." Most people therefore cannot afford to draw on contemporary representations of childhood where play and education is core to a child's future well-being.

At the age of ten, consensus was that children were expected to carry out duties alongside adults. Ten-year-olds were often perceived to have the physical and cognitive maturity of an adult, often referred to as 'women' (as opposed to a girl) and 'clever' (as opposed to ignorant). One female adult described her expectations of a 10-year-old girl, not only highlighting the perceived competence of a 10-year-old, but also the gendered nature of socialisation.

"What can be expected of a 10-year-old? That is pretty much a grown up. At that age she can do anything, she can wash t-shirts, she can wash your skirt, she can wash dirty clothes, that is a grown up. She can also fetch water, cook, mop the house and plaster it using cow dung. **At 10 years?** Yes, that's a woman." Female adult5 (Moja/interview)

However, through idiosyncratic and conflicting comments, a few adult informants would still give some indication of a 10-year-olds developmental stage by referring to them as doing light duties or describing some duties as dangerous. Fetching water from a nearby river for example was by one adult informant considered too dangerous for a 10-year-old due to the strong stream and crocodiles. Fifteen-year-olds were consensually perceived to be shrewder and have greater autonomy. He or she is more likely to be rebellious and assertive of his or her own rights and needs, but at the same time, has the maturity to do work without reminding.

"A 15-year-old is a child that knows what is happening around him/her, such that when he/she doesn't want to help you, he just doesn't want to. S/he can do the same as a 10-

year-old; the only difference is that s/he is now cleverer. Now, even if you don't tell her to do something, s/he will say, 'now when mother is away, I should do this and that'. She will just do things without you reminding her." Female adult4 (Moja/interview)

In light of their greater autonomy, many adult informants suggested that at the age of 15, children should be able to go out and find paid work such as assisting farmers with harvesting or working as maids in more affluent households. Alongside home duties, 15-year-olds were often expected to generate their own money and not ask their parents for money. This was not dissimilar to the expectations articulated for 18-year-olds, however 18-year-olds were now perceived to be citizens, a status that for some came with their acquisition of Kenyan national ID cards.

"An 18-year-old is now a grown up who should apply for an ID card to be identified as a Kenyan. S/he can even vote." Female adult7 (Mbili/interview)

All adult informants stressed the importance of formal education at each of the four stages of childhood described above. Although children spent much of their time in school, their contribution to the household in the morning, evening and during weekends are invaluable to many rural households.

"Adult1: A child is a wealth of the house.

Adult2: A child is a person who helps us with chores like fetching firewood, water and can be sent to other areas" Female adults (Moja/group discussion)

The importance of children was well summarised by one guardian, who in a conversation on children's contribution to households, said: "A child is a blessing from God." Much is clearly expected from Luo children. Poverty and dependence on continued subsistence farming means children's survival is partly dependent on their productive and reproductive contributions and the skills they learn from participating, they are 'a wealth'. The notion that work pays off was also prevalent amongst most of the children interviewed. Twelve-year-old John for example, in a group discussion, said that "we should work hard on our farms to avoid laziness."

Poverty and disease has not only exacerbated the need to 'work hard', it has also de-gendered many cultural practices and expectations of children. This is another example of how circumstances at one ecological level impact at another. Although the socialisation of children tends to be gendered, what happens in practice within some households is an adaptation to poverty and disease, further highlighting the fluidity of childhood.

"Once it was against Luo culture for a male child to go to a fire place, to cook in the kitchen. Today it has changed; they cook and do these duties. If one is blessed with 4 children and the first three are boys and the last born is a girl and the parent is sick, it will be the boys that cook and not the younger girl. Also, if you don't teach him to cook and his wife dies, his children may suffer. Today you cannot know who will die first." Female adult8 (Mbili/interview)

A count of the hours spent on various activities from the children’s daily diagrams, highlight how young carers, irrespective of gender, contribute equally to the care and work required to sustain their household (see Figure 8).

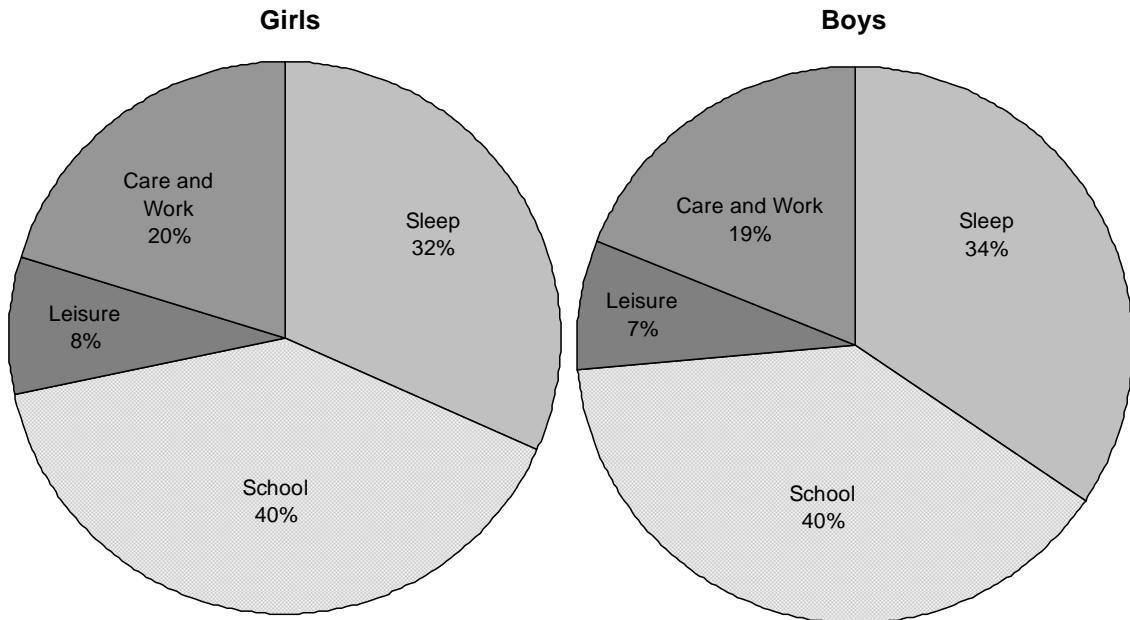


Figure 8: Average daily spending of time according to gender⁷

Although the average time spent on duties is similar, some of the duties the children do still follow gendered patterns. Whilst there is little difference between the hours and number of boys and girls who cook or provide care, twice as many girls over boys reported on cleaning and twice as many boys over girls reported on tethering animals. Nevertheless, many boys still engaged in cooking and many girls still tethered animals.

This adaptation and de-gendering of children roles also reflects a ‘cycling of resources’, with parents or guardians identifying the resources within a household, making the most out of those resources in response to their circumstances. Nevertheless, although most Luo families in rural communities continue to raise their children how their forefathers did and further try to adapt to this in accordance with their circumstances of disease and poverty, the tension between contemporary and ‘ideal’ notions of childhood and of how children live their lives in practice arise.

“I’m the one who should prepare food for the father. A child can only prepare food in case I’m committed in one way or the other, the child does cook, even when they are still young but the child should not do it, we just expect them to but they should not.” Female adult3 (Moja/interview)

⁷ This diagram does not take account of differences between weekend and week days, see Figure 9 for further details.

From the above it is clear that adults in Bondo are drawing on a number of different representations to give meaning to childhood. Luo culture is strong and succession of traditional values prevails. One contributing factor to this succession may be its close fit with challenges of disease and poverty – challenges that further emphasise the need for children to work. Nevertheless, disease and poverty has also meant an adaptation of traditional representations of childhood, with for example, gender roles being challenged and the erosion of certain cultural practices. Another representation of childhood entering the lifeworlds of people through the interdependence of ecological systems is the more rights-based approach to childhood, an approach that emphasises the importance of education and children’s rights.

A local social development professional notes the tension between the rights-based approach that he advocates and how people in rural areas perceive the right of the child. The generation gap, with children in school, benefiting from school-based children’s rights programmes initiated by NGOs and increased access to the internet, radio and TV, children and professionals in Kenya have increasingly adapted the rights-based approach to childhood.

“Previously, children were not supposed to be heard but now they are getting to know their rights and are therefore able to say ‘no’. People may think that this is a kind of disrespect. But I think they are asserting their right. But if you look at it from the child’s perspective, there is a contradiction between the act of child rights and what the people around them perceive to be right for the child.” Male SDP1 (interview)

The rights-based approach taught to many children is different from how lay adults in the communities perceive children’s rights. Although all adult informants believe children have a right to study, some also believe it is a right for the children to learn the skills required to survive in their context. Again, this belief is an adaptation to poverty and disease that characterise the district. The two senior social development professionals interviewed, agreed that people were seeing less of a use to go to school, simply because education did not bring food on the table and was increasingly perceived to fail to lift people out of poverty. This was articulated well by one SDP: “Emphasis to go and learn and come back is no longer there [...] As much as education is free, they will go to school and come back and eat what? Instead many want to go to the lake and do fishing, many opt to do small jobs so that they can have food at home.” Nevertheless, with a consensus that education remains important, households are adapting the rights-based approach to childhood, and combine it with their own understanding of rights, which include children’s rights to education and to work.

“Now we should go to chief barazas (weekly community meeting with the local chief) and tell them to give the children their rights. A child should be given chance to do their duties, a child should be given a chance to study.” Male Adult1 (Moja/interview)

These adjustments of rights-based approaches to fit their local context highlight how difficult it is for them to follow Western rights-based understandings of childhood. A social development professional from Bondo also gave a clear example of how disease, poverty and lack of alternatives can undermine the helpfulness of Western rights-based approaches to childhood.

“A child is supposed to go to school. When they are working they are denied their right to go to school. But then sometimes we are in a dilemma and sometimes in a very precarious situation; if you find a child fishing or doing work and visit the home of the child and find a single mother who is bedridden and sick - the child was only looking for food for the mother. Now there is a situation sometimes, sincerely speaking, when we are sometimes left back, we don't know what to do because there is somebody who is sick and there are other siblings, the child here is 14 and he has to bring food for these people here. Now, if you insist that this one must go to school then what happens to everyone else in the household?” Male SDP1 (interview)

Although I have only presented a few findings at this stage of my thesis, some of the difficulties faced by young carers have come to light. The demands of economic survival compromise their education and disease and ailment of guardians has added to their workload. Work/care vs. education and survival vs. hope for a better future are two of the stark dichotomies running through my data that I will return to later.

This subsection suggests there is no single 'other' notion of childhood amongst the Luo. Disease, poverty, culture and rights-based (Western/universal) conceptions of childhood are all variables impacting on how people at different ages and positions perceive childhood differently. The variables are used strategically and ideologically in a complex interchange helping people make sense of the representations and circumstances that surround them. The different representations and adult understandings of childhood give rise to symbolic tensions that all contributed to an idiosyncratic understanding and adaptation of childhood. The forthcoming section will explore how these representations and understandings of childhood influence relationships between children and adults.

4.1.2 Luo children's relationship with adults

As illustrated in Table 14, a major organising theme contributing to our understanding of the expectations adults have of children (and vice versa) is the theme of adult-child relationships. Expectations of adult-child relationships amongst the Luo are characterised by respect and obedience for the elderly, giving an indication of how children respond to the roles and responsibilities they are given. Numerous proverbs testify to the importance of children listening to adults, emphasising that failure to do so will have consequences. One Luo proverb says that “a child that doesn't respect the adult teaching will not succeed in life” (Dhluo version: “*Nyathi maok odewo puonj jomadongo ok bed gi ngima maber*”). In order to develop ways of understanding coping as a function of children's capacity to participate and navigate their way to resources that sustain their well-being, it is important to explore the relationship between children and the source of many of those resources, namely the adults.

The vulnerability of young carers and OVC forces many children to seek support from adults. Their vulnerability and dependence make them a category in need of adult support – this is consensually

illustrated by how dependent the children are on their fostering guardians (or caregivers as they are referred to in the quotes) to have a bed and a base to which they belong.

“Children need someone to help him/her with clothes and books. In case the parents are dead, they need someone who can stay with them and take care of them.” Joyce, 12 (Mbili/interview)

This need to stay with someone makes the children grateful for their foster parents. Knowing that children depend on them, foster parents make clear that obedience and respect by the foster child is an essential precondition for the children to stay with them. Without such obedience and respect, the fostering relationship could not exist.

“She respects me because I am her caregiver. She respects me like my own child and her mother also taught her to respect me. If she doesn’t do so, she would not be living with me.” Male adult7 (Mbili/interview)

The fragility of some fostering relationships is well illustrated by 15-year-old Carlyne who had been bouncing between guardians who died one by one, all of which required care. She ended up with her grandfather. She did not go into detail on the way she and her little sister were maltreated, however the fact she had to spend nights outside the house amongst wild animals, forcefully or voluntarily, gives an indication of not only how fragile fostering relationships can be, but also how they can be subject to abuse.

“When I was young, my mother passed away. My father was the first one to die. Now I was left with my grandmother who later died and I then had to stay with my grandfather who was mistreating us badly. I had to survive with my younger sister. At times we would even spend our nights outside. We occasionally met hyenas but fortunately nothing happened to us.” Carlyne, 15 (Mbili/interview)

Fortunately, only a minority of the children interviewed expressed such extreme incidences of abuse. Most children seem to be grateful for their fostering home and the stability it gives, even if the relationship is constructed on a premise that the adult benefits from fostering an orphaned child. During an interview 17-year-old Fanuel was comparing himself with other non-caring children. He said that whilst other children get a chance to rest, “I do work and do one thing after the other, but with no resting.” In Fanuel’s case, this is not reflective of an overt abusive relationship, but reflects a more covert exploitation encouraged by his foster parents who draw on the representation of parentless children as vulnerable and in need of adult support – a representation that encourages Fanuel to please his foster parents in order to reciprocate what he is given (a place to belong). And Fanuel is indeed grateful for his new home. His foster parents dominated his photovoice exercise and he said: “I wanted to talk about these photos because they show those who help me, encourage me and this has enabled me to do the right things.”

There was consensus amongst the children on how to build working foster relationships. Children showed their gratefulness by giving their guardians respect and by living up to their responsibility as ‘helpers’ – in return for a place to belong to and foster care (with the extent of care differing significantly).

“I always help out my guardian and she always gives me food at the right time and place. My guardian is very clever and honest; I give her respect and live up to my responsibility all the time.” Loyce, 14 (Moja/photovoice, see Picture 1)



Picture 1: Photovoice picture by Loyce, age 14

In satisfying the expectations of guardians, many of the interviewed children act strategically and with an awareness of what other (or not) alternatives that are available to them. Seventeen-year-old Fanuel, whom we met earlier, makes a conscious decision to relate well with his foster parents and live up to their expectations made explicit through disciplining (giving of advice).

“Sometimes I sit with my guardians who advise me on how to be at home and how I should relate to others, then I wash the clothes and ask them if there is anything else they want me to do. I try to be close to them and relate well with them and do what they wish done.”
Fanuel, 17 (Mbili/interview)

Fanuel’s foster parents have already taken him to school, something he might not have been able to do without the resources available from his guardians, and he has hopes for greater benefits if he works hard to help out his elderly guardians. What also comes from Fanuel’s quote is the role of fostering guardians in disciplining the children on how to relate (read being respectful) to others. One adult in a group discussion said: “We have to provide them with knowledge and teach them to be good people.” Because orphaned children are aware of their vulnerable position and therefore motivated to live up to their responsibility as obedient children, they often stand out from other children.

“The difference between a child whose parents are still alive and well and the child who is living and caring for the ill or old adults is that the child living with the sick or old grandmother is clever because she knows that if there is no water, she is the one to fetch it.

She checks if there is flour, or whether food is lacking. But the one living with the parents relaxes and knows that the mother will do this and that.” Female adult4 (Moja/interview)

The contrast between ‘good/alert’ and ‘obedient’ young carers and ‘lazy’ and ‘relaxed’ children living with their biological parents become all the more obvious when the changes occurring amongst the Luo are considered. Conceptualisations of children’s rights are trickling down to a community level and children are increasingly empowered by their awareness of this. This has been noted by a local professional, whose job is to promote children’s rights, and yet paradoxically uses a hierarchical language to describe how children are increasingly lacking respect for adults.

“The way that I perceived my superiors and the way that the children of now are looking at their superiors are quite different. In short, there is a lack of respect that is there between the adults and the children.” Male SDP1 (interview)

His use of the word superior indicates how he, as a child rights activist, is still influenced by his social and cultural upbringing. Adult informants also made note of how relations between children and adults have changed.

“I think that children should be taught about discipline. In the past people were very respectful to each other and the children were very obedient to their parents.” Male adult1, (Mbili/interview)

A paradox transpires from the relationship between children and adults. As much as adults allow children to engage in work and activities that require competence in practice, the discipline and surveillance adults impose, seem to deny the children their symbolic competence. This is part and parcel of the hierarchical Luo society where age is as much a dimension of oppression as gender. As a number of proverbs indicate Luo adults are determined to undervalue youth – seeing them as dependents in need of adult control and punishment to keep them in line. The proverb ‘a stitch in time saves nine’ (Dhluo: *Chakochon loyo dhi ajuoga*) refers to the importance of adults disciplining and ‘correcting’ children in an early age, as it will benefit the children in the future. ‘Counting sticks’ is another Luo proverb (Dhluo: *makosa yaheshabiwe*) that refers to adults counting the number of times a child should be punished – often serving as a warning to children.

As we saw earlier with the eviction of 15-year-old Carlyne and her sister, there can be consequences for children who are not living up to the expectations of their guardians. This unfortunate event represents the perceived fragility of foster parent-children relationships and symbolises the power guardians have over orphaned children. Orphaned children are therefore disempowered and out of respect for what they are receiving (a place to belong and discipline), go to great lengths to live up to the expectations of their foster parents. From an analysis of the relationship between children and their foster parents, it transpires that children’s willing performance of physical labour can help them navigate access to a new home and to all the benefits associated with belonging and attachment to adults.

However, this finding should be understood with an appreciation of the differences that make up these caring experiences. Children who care for a close ill family member, like a mother or a sister, are likely to be driven more by love than those who care for an ailing neighbour or ageing step grandmother, who might be driven by more strategic interests. I will return to the complexity of these circumstances in Section 4.2.

Whilst there has been an increase in the number of children without living biological parents, there are also social reasons to why the concept of orphanhood has emerged in Luo society in the past decade. Drawing on basic themes 10-12 from Table 14, the next subsection will explore some of those reasons.

4.1.3 The 'emergence' of the concept of orphanhood

Despite disease and pockets of poverty, Kenya's economy has in the past decade been one of the fastest growing in East Africa. As the previous sections have indicated, modernisation and policies that reflect our increasingly globalised world has meant a departure (albeit with some tension) from some traditional ideas, doctrines, and cultural values in favour of contemporary values. One change many adults commented on was the way in which orphaned children are cared for. Implicit in the interviews with adult informants was the idea that the notion of orphanhood was a historically recent development. They often contrasted 'contemporary' family life, which they depicted as more atomised and nuclear with 'traditional' family life. In the latter, children and families were depicted as part and parcel of a wider network of community relations, support and reciprocity. They characterised the past in terms of closeness where support was easily accessible and plentiful as a result of better socioeconomic conditions and greater senses of collective responsibilities. In their view, contemporary social life is a result of overpopulation, poverty, change in values and terminologies used to describe orphaned children.

One change to contemporary social life, which has had an impact on social values, was the introduction of education. One female community leader articulated the link between education and contemporary social life neatly by saying: "Now I can say that education is here because of modern life, which was brought about by Wazungu [white men]." Although she was positive about the access to formal education, she subsequently described the difference between children of the past and children of today to stress the negative impact of modern life as brought by Wazungu: "nowadays children disobey their parents", "children of the past were not dating men before the age of marriage but children of today do not care, they just date them." She also made a note of how the elderly have changed, explaining the diminishing role of grandmother's in educating girls through their rights of passage to womanhood: "Nowadays our grandmothers are not bringing the girl child close to them." This change in social values, poverty and disease were perceived to make OVC more vulnerable than non-orphaned children. Partly because of contemporary social life and partly because of poverty and the inability of community members to support all needy children, children without parents are to a lesser extent perceived to be children of a community.

“Childhood in Bondo and amongst the Luo in particular has changed. When I grew up I was a child of the community, I wasn’t a child of my parents alone. My aunties, my uncles, I was calling them mother and father. That closeness is no longer there.” Male SDP1 (interview)

The closeness referred to by the SDP meant that children who in the past lost their parents prematurely were catered for by people around them. An adult from Moja exemplifies this well.

“In the past children were given food in their hands and so called ‘orphans’ you gave a little bit more because there is nowhere she will get apart from there. That way she will not realise that she is an orphan. That’s how orphans were being cared for in the past.” Adults11, (Moja/group discussion)

The above quote indicates that ‘orphan’ and orphanhood are new concepts to the Luo. One adult from Mbili community cannot find an equivalent translation in the local Dhluo language.

“An orphan whose both parents are dead is known as a total orphan in English but I don’t know how I can put it in our mother tongue.” Adults12 (Mbili/group discussion)

Although the Luo may not have had the vocabulary of orphanhood, socioeconomic changes has meant that orphanhood, in the vulnerable sense, is a reality. Deprivation and high rates of inflation have made it more difficult for community members to support children in difficult circumstances.

“In the past 10 cent was a lot of money and even 5/= could be used for budgeting. Nowadays life is expensive and that is the problem we have so life cannot go on well.” Adults11 (Moja/group discussion)

One social development professional gives an example of how population growth and poverty undermines the traditional African community.

“When I was young we had plenty of animals; goats, sheep and cows you see. This is no longer the case because most of the land is now owned by people who do not like other animals to enter and feed off their land.” Male SDP2 (interview)

Aside from the erosion of nutrient-rich soils and less land available for agriculture and animal rearing, changes in attitude were also reported. One adult argues that “laziness” is a contributor to failure in fruitful harvests, people want oxen to plough the land instead of doing it manually.

“I would like to add laziness, in the past there was no ox-plough and our great grandparents were cultivating land perfectly fine. They could cultivate up to 2ha of land and there were plenty of sorghum and no hunger. Nowadays if the land is not ploughed using ox plough, people won’t get their land cultivated. That’s why there is hunger.” Adults12 (Mbili/group discussion)

In a context of scarce resources, some informants spoke of OVC susceptibility to abuse (forced to work) and discrimination (not benefiting equally from the resources available). Fifteen-year-old Michael, for example, sees orphaned children as a particular target. He says “there are some children in our community who are orphans, some are being mistreated and me I’m not mistreated in our house and so we are different.” Michael is not yet an orphan, but cares for his sick mother, yet acutely aware of the potential challenges ahead. Many of the children saw orphanhood as a disadvantage to their well-being. A social development professional with experiences in local court cases related to the well-being of children, argues that their orphan status makes them more prone to abuse.

“People often abuse orphans; they are prone to rape because they have to go to many places to look for food for others. And some people unfortunately think that they can just molest an orphan and nothing will happen. Poverty also makes the orphans see their bodies as an asset that can bring them. Many times they are also denied their inheritance, being told that they can go and get married elsewhere and not be a problem here.” Male SDP1(interview)

Whilst this statement underscores the vulnerability of orphaned children, abuse can take many different forms. The social development professional highlighted some of the more serious forms of abuse, including rape or denial of inheritance. However, abuse also happens within foster families. Although some adults were adamant about treating their fostering children like their own, a number of adults set out to justify why they discriminated between their own children and orphaned children. Explanations often centered around high levels of poverty and lack of food.

“Sometimes I’m left with three orphans plus my own five children and when it is time to eat I’ll send the orphans out to work so that my children get enough to eat.” Adults12 (Mbili/group discussion)

The growing number of NGOs targeting orphaned children has contributed to the emergence of ‘orphans’. There was agreement in a group discussion on the role of NGOs in changing notions of orphanhood.

“Changes in notions of orphanhood may be due to the support coming for the orphans. So if the caretaker tells you that I’m living with an orphan, she might get support from somewhere.” Adults12 (Mbili/group discussion)

At the face of it, this is a positive thing with support from NGOs and government departments reaching those in need, giving people a financial incentive to help orphaned children that they would not otherwise have had. However, some informants in the same group discussion said that the need for incentives reflected a “lack of love” within the community (again due to modernity and poverty) which has wider repercussions and could mean that the fruits of the incentives do not reach the orphaned children as intended.

This section has shown that the vulnerability of children is determined by a number of variables, be it from community breakdown, inflation and poverty, population growth and definitions or understandings of orphanhood. These variables were often referred to as a result of modernity, which in turn was symbolically associated with colonisation and 'white man'.

Such variables and perceptions interact with each other in the ecological and social context under study and determine the vulnerability lived and perceived by children, testifying that NGOs are operating in a very complex environment. Social representations of childhood (such as children as 'helpers') and the vulnerability of orphaned children all come together and shape the relationship between foster children and their parents, a relationship based on unequal power-relations, leaving young carers (and OVC more generally) susceptible to abuse.

This section has presented some of the socioeconomic and psychosocial forces and challenges that not only impact on the well-being of young carers, but may also hinder their access to much needed resources. This section has provided some background that will help us understand and contextualise the forthcoming sections that look more directly at the circumstances of young carers.

4.2 The circumstances surrounding young carers

The circumstances of young carers are highly fluid and should not be considered static. A simple tally of their daily diagrams gives some indication of how the children spend the majority of their time (see Figure 9). Figure 9 shows how the participating young carers, on average, spend 24 hours during the week and during a weekend. The diagrams show that education plays a major role in their life and that they do take time for leisure activities. These cross-sectional snapshots do not indicate the periods in which the children have to drop out of school to provide care and the diverse circumstances that characterise the children – something which this section seeks to elaborate on.

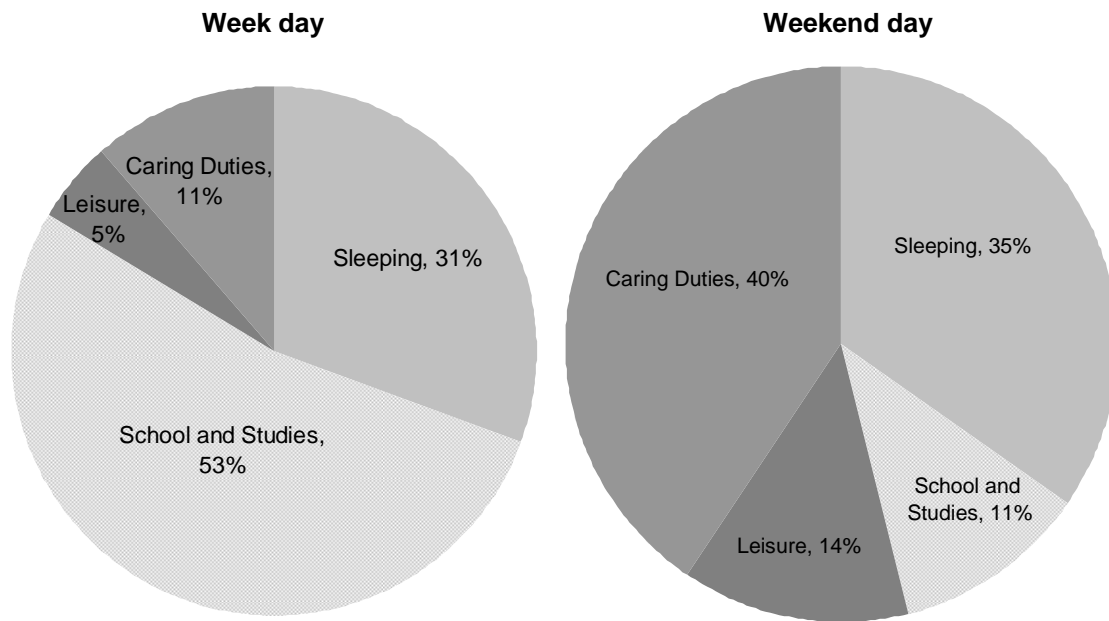


Figure 9: 24 hours of a young carer (average)

This section gives an insight to the multifaceted nature of their caregiving circumstances. As Table 15 illustrates, it will do so by firstly elaborating on the external factors that encourage children to take on caregiving responsibilities and secondly look at who those care recipients are. The final subsection will outline some of the roles and responsibilities children take on.

Table 15: Global theme: The circumstances and perceptions surrounding young carers

Organising themes	Basic themes identified	Issues discussed	Codes
Becoming a young carer (discussed in Section 4.2.1)	13. AIDS is often a cause of caregiving.	<ul style="list-style-type: none"> • Successive deaths of family members • Stigma • Symptoms and weakness 	<ul style="list-style-type: none"> - Disease and family background (26 children, 1 adult) - HIV/AIDS (9 children, 3 adults)
	14. There are socio-cultural reasons to why children are likely to engage in young caregiving and occasionally sent away to do so.	<ul style="list-style-type: none"> • Restrictions on who can care for who • Adult/child customs • Gender • Migration 	<ul style="list-style-type: none"> - Cultural traditions impact (14 children, 9 adults) - Sent to care (10 children, 2 adults)
	15. Young carers often come from poorer households and/or families with limited support.	<ul style="list-style-type: none"> • Poverty related struggles • Disease • Accidents • Struggles 	<ul style="list-style-type: none"> - Family circumstances (8 children) - Lack of support (11 children) - Need additional support (3 children, 2 adults) - Poverty (23 children, 8 adults)
	16. Many young carers want to provide care and support – often driven by reciprocity, future support and social recognition.	<ul style="list-style-type: none"> • Always support the needy • Love for the vulnerable • No one else to do it • Reciprocating care and support 	<ul style="list-style-type: none"> - Commitment to provide care/support (5 children) - Felt need to act (15 children) - Reciprocity (19 children) - Strategic caregiving (20 children)
	17. Caregiving is rarely a one-off experience but a recurring duty.	<ul style="list-style-type: none"> • Short-term • Long-term • Recurring 	<ul style="list-style-type: none"> - Duration of caring (5 children)
Care recipients (discussed in Section 4.2.2)	18. Many young carers provide care and support for ailing parents.	<ul style="list-style-type: none"> • Nursing duties • Head-of-household • Symptoms 	<ul style="list-style-type: none"> - Sick parents/guardians (36 children, 2 adults)
	19. Many young carers provide care and support for younger siblings.	<ul style="list-style-type: none"> • Younger siblings • Orphaned children 	<ul style="list-style-type: none"> - Caring for children (13 children)
	20. Many young carers provide care and support for elderly people.	<ul style="list-style-type: none"> • Old age inabilities • Fetching of water and firewood • As children of the elderly die of AIDS, grandchildren need to take care 	<ul style="list-style-type: none"> - Caring for community elders (6 children) - Caring for grandparents (45 children, 8 adults)
Caring roles and responsibilities (discussed in Section 4.2.3)	21. Children are important to household livelihoods.	<ul style="list-style-type: none"> • Children help out with cooking and cleaning • Children of all age groups assist 	<ul style="list-style-type: none"> - Young caregiving (46 children, 7 adults)
	22. Young carers contribute significantly to the household economy.	<ul style="list-style-type: none"> • Primary source of income • Adult responsibilities • Missing school • Sustaining household 	<ul style="list-style-type: none"> - Child-headed households (19 children, 5 adults) - No rest (4 children)
	23. Young carers provide significant personal and nursing care.	<ul style="list-style-type: none"> • Washing bodies and applying creams • Cooking, feeding and cleaning • Administering medication 	<ul style="list-style-type: none"> - Personal care (33 children)
	24. Young carers provide mental and emotional support for the sick and old.	<ul style="list-style-type: none"> • Encouragement • Share happy stories • Being present and caring 	<ul style="list-style-type: none"> - Mental health support (5 children, 2 adults)

4.2.1 Becoming a young caregiver

To understand young caregiving, one must understand the route in which children engage with caring responsibilities. This may also give us clues to how young carers could best be supported (e.g. if one route to caregiving is more harmful than another). As the route to caregiving is contextually and socially determined, this will be the focus of this subsection. The first half will look

at external factors such as HIV/AIDS, poverty and culture and the latter half will look at how the children rationalise and internalise the reasons to why they have become caregivers. It is important that quotes are read with an understanding of the social representations outlined in Section 4.1 (e.g. children as 'helpers' and their respect for their elders, particular in a foster child-adult relationship) as these representations impact on the children's ability and willingness to offer the care outlined in this section. The link between social representations of childhood (vulnerable children) and coping with care will be discussed in greater detail in Chapter six.

AIDS is arguably the root cause of much young caregiving. Although children rarely mention or know that it is AIDS which has made them young carers, the accounts and history profiles produced by the children do suggest that AIDS is the disease that disabled their guardians. Some of these indicators include the death or ailment of both parents within a relatively short period, observations of parents taking drugs regularly, sores and swollen joints, the secrecy surrounding the disease and the ailment of newborn siblings.

"I was born in a family of two. The second born was a girl child and since she came into the family, we haven't seen our father. We were staying with our grandmother and we could see that our mother was taking medicine, but we didn't know what it was for. She later died, so we were left with our grandmother and my sister who was also sick. I frequently took her to the hospital and burnt charcoal to get our daily bread." John, 12 (Mbili/interview)

"My father's hands started swelling, this continued and the hands got very big. I felt pain when I saw how my father was suffering and the money he had earned was disappearing fast. He was taken for prayers but the condition never changed. He went back to Nakuru and another spell affected his legs. I really felt hurt by this. I was always the one caring for him. I was washing the feet, the swollen legs, giving drugs and by then my mother was also sick. His hands were all swollen and so I was pressing this stuff out of the swollen hands, used dressing and put drugs on the legs, prepared his food, spoon fed him as he could not eat by himself because of the sores all over his body." Samuel, 13 (Moja/interview)

Children not only provide ad hoc care for their immediate family members, but are also actively encouraged to provide care for their ageing grandparents. Many children are sent away by their parents or other family members to provide care and support for ageing grandparents, reflecting the role of children as 'helpers' outlined in Section 4.1.

"My grandmother had a problem and I came to stay with her. Her leg has a big wound. She was trying to get by, but couldn't and that is why I came here, to help her." Jane, 17 (Mbili/photovoice, see Picture 2)



Picture 2: Photovoice picture by Jane, age 17

“The children can help in various ways, they can assist the grandmother to get what she needs, prepare porridge, wash her clothes etc. If I go and see that she is in a serious condition, when I come back, I send my child and instruct him/her to help with whatever things she need. If the sons and their wives don’t help the grandmother, their daughters will send their children to help out.” Adults11 (Moja/group discussion)

In a context of HIV and poverty it is increasingly difficult for adults to take care of their parents. This not only encourages the migration of grandchildren to stay with grandparents, but also between children and their ageing neighbours.

“She [A neighbour] only has one daughter and since the daughter refused to take care of her, she came to my mother and asked for permission to allow me to stay with her and help her out.” Jane, 17 (Mbili/interview)

A combination of poverty and the absence of biological and fostering parents to facilitate with the caring of those less able meant that many children had to take matters in their own hands. Seventeen-year-old Carren for example, who cares for her younger siblings, sees no other way but to work to cover their needs and does so gladly, drawing on the representation of being a ‘helper’ and ‘a good child’.

“I enjoy looking after my younger siblings; I wash them, play with them and sell firewood, cut wood for burning charcoal, because it is the only way to cover our needs.” Carren, 17 (Mbili/interview)

Likewise, Syprose and Jael, both 14 years of age, found themselves as the only ones around to do the caring. As with Syprose, this is typically the case of children who have been sent away, to care for someone.

“Since he [sick grandfather] was unable to do these chores, I just did them without difficulty; after all I was the only around to do them.” Syprose, 14 (Mbili/interview)

“Our mother had been sick for a while and I was the one was caring for her as there was no one else to care for her.” Jael, 14 (Moja/draw-and-write, see Picture 3)



Picture 3: Draw-and-write picture by Jael, age 14

At occasions there are other family members around, however their support can be limited and impeded by social and cultural factors.

“I cared for my father when he was seriously sick; I could not go to school for a year since there was no other person at home. Since my father was bedridden in his bedroom, my grandmother could not help as she cannot enter his room. This made me not to go to school for a year. My grandmother could prepare food for him but could not give him since he was in the bedroom; so I was the one giving him food, spoon feeding him.” Zeddy, 16 (Moja/essay)

Zeddy also had to change his father's clothes, wash him and his clothes and ensure the bedding was kept clean, simply because Luo tradition does not allow for his grandmother to enter the room of her son. Fourteen-year-old Catherine also felt the inability of her grandmother to provide care. However, her grandmother had been supportive and helpful up until she got ill and because Catherine was the first born child, the caring responsibilities landed on her shoulders.

“Last year in April, my great grandmother got sick and went to her home. I was sad about leaving school to take care of my sick family. During that time there was drought and it was a hard task since all the family members were looking at me because I was the first born child.” Catherine, 14 (Moja/essay)

The durations over which children provide care differ substantially. For example, Carren who is now taking care of her siblings, was sent away for 18 months to provide care and support for her grandmother.

“I stayed with her helping her for about one and a half years and then my mother came and took me back since my grandmother was now alright and able to do the household duties.” Carren, 17 (Mbili/essay)

Although it can be limited to 18 months for some young carers, for 15-year-old Carolyne caregiving is a long-term affair, in which one caring experience leads to another.

“I kept on checking on her since she needed water and had to have her position changed all the time. After I had prepared her food, I left it to cool and then supported her to sit and fed her. I had to leave school since she could not be alone due to her serious condition. When her condition worsened I then took her back to the hospital. She could not talk. I knew she was dying, but we went to the hospital anyway. She was admitted and we stayed there for two days. Her condition improved but she soon died. After her burial, I went back to school, but shortly after, my grandmother fell sick and I started caring for her. I left school again as she was too sick to do anything by herself.” Carolyne, 15 (Mbili/essay)

So far I have outlined some of the external factors that facilitate young caregiving. The second half of this subsection will look at some of the internal factors that encourage children to provide care. Religion and faith plays an enormous role in the lives of Luo people. Many children use God’s blessings as an incentive to care. Religion gives them a reason to care.

“It is my personal view, that if I care for a sick person, I’m happy since I get blessings from God because it is not good for someone to suffer while you are there.” Samuel, 13 (Moja/interview)

“By helping the needy we are also blessed by God for our help.” Michael, 15 (Mbili/photovoice, see Picture 4)



Picture 4: Photovoice picture by Michael, age 15

If the external circumstances present, many children will be happy to help out their parents due to the strong bond of love between them. Some children, like Pascal, would chose to help their parents if the opportunity is there.

“Because I love my father so much, I chose to be with him and help him out.” Pascal, 14 (Moja/interview)

“I loved him and I could not leave him alone.” Catherine, 14 (Moja/interview)

Many children felt they owed their parents or fostering parents something for the upbringing they have been given. Many young carers therefore see themselves reciprocate the caring they once received from their parents.

“What encourages me to take care of my mother is that she was the one who gave birth to me, she brought me up and also cared for me, I did not see any reason of neglecting her, I have to assist her in problems, I love my mother.” Francis, 14 (Mbili/interview)

This is not only the case between children and their biological parents, but also between the children and their fostering parents.

“I took this picture because it reminds me of the help I have given this woman and how she has helped me. I remember everything she has done to me, from my childhood to now. I was once unable, now she is unable.” Sharon, 15 (Mbili/photovoice, see Picture 5)



Picture 5: Photovoice picture by Sharon, age 15

4.2.2 Care recipients

Children were found to provide care and support for people of all ages and across relationships. I identified four groups of people whom children were found to provide care and support for: 1) Ailing parents; 2) Ageing and ailing relatives; 3) Younger siblings and 4) Abandoned community members. For many of the children, caring is not constrained to one individual and one experience, but a role that plays an important part of whom they are and have become as their caring responsibilities involve an increasing network of people.

“I always care for many people. In fact, I have been caring for children, adults, my parents, relatives and many other people. In our village, I’m caring for the aged by fetching water, firewood and washing their clothes. I sometimes cook for them.” Carren, 17 (Mbili/essay)

For the majority of the children involved in this study, their caring experience began with their parents when they were young. In 2003, when Beryl was 10, she lost her father and a younger sibling, both of which required her care running up to their deaths as her two mothers were also getting sick. Beryl’s older mother (her father’s first wife) died in 2005, leaving Beryl alone with her biological mother who sadly passed away shortly after she wrote this essay about caring for her.

“My mother got sick, but it was not all that serious in the beginning, however the sickness persisted, I started taking her to the hospital, I looked for food whilst I was also going to school. I had to ensure that I left school early to look into ways of getting flour. Now she is worse, I wash her; I look for food, fetch water. I cook and feed her and take her to the bed. In the morning I wake up very early, around 3am, help her go to the latrine and prepare for her breakfast and fetch water. Before going to school I give her drugs and breakfast. I go to school until around 4.00pm, when I come back I usually find she has helped herself [defecated] in the bed and I have to clean her and wash the bedding.” Beryl, 14 (Mbili/essay)

Following the death of their ailing parents, many orphaned children move in with ageing relatives such as uncles and aunts and grandparents. Because of their old age, many of these elderly relatives are struggling to take care of the orphaned children and themselves and the caregiving experience of the children often continues.

“This photo [see below] shows my grandmother whom I am taking care of. She is sick up to now and she can’t be alone for many hours. I ensure she gets what she needs. I also ensure that water is in the house, wash it, wash her clothes, utensils, cook and give it to her.” Syprose, 14 (Mbili/photovoice, see Picture 6)



Picture 6: Photovoice picture by Syprose, age 14

One adult from Mbili community exemplifies how useful and normal it is for lonely grandparents to have a grandchild taking care of them.

“Maybe somebody is old and therefore doesn’t have many relatives to care for him or her, but he or she is blessed with a grandchild, the grandchild will take care of the old grandparent.” Female adult6 (Mbili/interview)

This normative notion of children taking care of grandparents in some cases means that young carers’ first caring experiences can be with ageing grandparents. The first caring experience can also be of younger siblings. Describing a photo of heaven, 13-year-old Salome describes his first caregiving experience.

“I want to talk about my sister’s illness from when it started to the time she died to rest in heaven [he took a picture of heaven, see Picture 7]. My sister started to get sick little by little and she was sleeping most of the time unable to do anything. She got weaker and weaker and this was at a time when my mother had gone to bury her father. I had no choice but to stay at home and be with her and feed her like as if she was a little child. She could not eat by herself and could only eat very small portions. When I finally noticed that she could eat something, I gained some strength. I was washing her, washing her clothes and I

gave her drugs within the correct intervals. I also cooked for her. I couldn't move away from her and applied oil to her body." Salome, 13 (Moja/photovoice, see Picture 7)



Picture 7: Photovoice picture by Salome, age 13

Children not only take care of their immediate or extended family. Also fellow community members benefit from the agency and participation of children providing care. Seventeen-year-old Jane, for example, reports on her experience of taking into care an orphaned boy who had nowhere else to go.

"The child is left alone; no one is there to help this child with food, except from me. I took the photo [see below] of this child because I help him in certain ways. I love him and assist him by washing his body, giving him food, buying him clothes if I have enough money and play with him to make him happy so that he doesn't think of the situation of his parents. He sleeps in my room and I wash his clothes." Jane, 17 (Mbili/photovoice, see Picture 8)



Picture 8: Photovoice picture by Jane, age 17

Similarly, 13-year-old Samuel reports on his experiences of taking care of an ageing neighbour. Samuel emphasises that nobody else was there to care for him and therefore feel a sense of pride in his actions. Samuel's willingness to care for his old neighbour may be encouraged by his respect for older people, but also the power of being able to keep someone well and alive.

"I want to talk about this old man because has lost all his children and I was his neighbour and the one who cared for him. I took him out as he couldn't walk and took him back to the house, cooked for him and gave him food. I was helping this man until his death. I was fetching water, firewood and cleaned him and his house. I drew this old man because he was very old; his wife had also died, so I was caring for him as he was too old to do anything." Samuel, 13 (Moja/draw-and-write, see Picture 9)



Picture 9: Draw-and-write picture by Samuel, age 13

Through my description of the type of people the children provide care for, an insight to some of their roles and responsibilities has been revealed. The next section goes into greater thematic detail with some of these roles and responsibilities.

4.2.3 Caring roles and responsibilities

As Table 15 indicates, the participating children appeared to take on one or more of three roles and responsibilities. These include 'head of house' responsibilities, nursing duties and emotional support. Children with 'head of household' responsibilities had to make decisions and do the thinking that adults would otherwise be expected to do.

"The children caring are the ones who have to think instead of the old." John, 12
(Mbili/interview)

Most children also had to take on income generating responsibilities, making them the breadwinners of the household. For the majority of the children, income is generated through cultivation of their gardens and selling of their produce at a nearby market place. As with 15-year-old Michael, the pressure to generate income for survival has enabled him to think of ways to optimise his land by having a tree nursery fencing his garden. Although it will take years before the trees can be sold, they give him a sense of purpose and hope for the future.

“I took this photo [see below] of my garden because it has helped me in many ways and helped me overcome many problems. It has helped me getting money and ways to assist the sick. It is also my tree nursery. It gates the land by planting trees. The land has helped me in so many ways. If I sell some of my produce, I have enough money to feed my family. But I lack some.” Michael, 15 (Mbili/photovoice, see Picture 10)



Picture 10: Photovoice picture by Michael, age 15

The next chapter (Chapter five) looks at how young carers cope with the circumstances and goes into greater detail of what income generating activities young carers are involved with. Besides contributing significantly to their households, what defines them as young carers is the amount of personal and nursing care they provide. Much of the care is intimate and involves bathing, massaging and feeding of the sick.

“I help my guardian by washing her, massaging her body with a cloth dipped in hot water and cleaning her feet.” Josephine, 16 (Moja/essay)

“I drew this picture [see below] of my mother to share with you the kind of caring I have done for her. I was caring a lot for her, I was washing her, bathing her, washing her feet, cooking for and feeding her.” Mark, 13 (Moja/draw-and-write, see Picture 11)



Picture 11: Draw-and-write picture by Mark, age 13

Many children will at some point have taken on more advanced nursing responsibilities, attending to their loved ones in the hospital, mediating between doctors and treatment, buying and bringing to the sick their medicines, often being responsible for the dose and timely intake.

“I was always with my mother at the hospital to ensure that when she woke up, a doctor would come and see her. I was washing her, washed her clothes, bought and brought her the drugs needed for treating her. I was doing everything for her in the hospital. My uncle came to pay the hospital bill. She was discharged, felt well but no strength.” Everline, 14 (Mbili/essay)

Aside from providing physical care, many young carers also provide emotional support for those sick. Seventeen-year-old Carren for example, based on her experiences, is providing us with some suggestions to how caregivers can provide encouragement for someone who is sick and with little hope in life.

“Don't feel pity for the sick, you don't say things that make them loose hope in life. You should be happy with the sick. Always show love when you are washing the sick. Don't quarrel with him/her, be patient as you wash him/her; show the sick different sitting positions in a polite way as you wash their body. You should encourage the sick person regularly; telling the sick that s/he is almost healed.” Carren, 17 (Mbili/interview)

The intimate nature of their care, physically and emotionally, is what distinguishes the duties of non-caring children from those of caregiving children. As I pointed out in the beginning of this chapter, many of these intimate care duties are culturally inappropriate and thus qualify caregiving children as a particular group. As the quotes from this subsection indicate, many of the caring children describe their circumstances gracefully and with little reference to negative consequences. However, the responsibilities and experiences of the young carers do not come without challenges, something on which the next section will elaborate.

4.3 Challenges faced by young carers

This section looks at some of the challenges faced by young carers. As Table 16 illustrates, the challenges described by the children fall under three categories. Firstly, poverty and destitution, covering issues of malnutrition, access to water, material needs and poor housing. Secondly, psychosocial challenges such as lack of support, stigma, and fear and bullying and parental bereavement. Finally is the issue of managing their school and education, something they give great importance.

Table 16: Global theme: Challenges faced by young carers

Organising themes	Basic themes identified	Issues discussed	Codes
Poverty and destitution (discussed in Section 4.3.1)	25. The funds available to many young carers are inadequate.	<ul style="list-style-type: none"> • Lacking clothes • Lacking school related materials • Leaking houses 	<ul style="list-style-type: none"> - Material needs (17 children, 1 adult) - Poor housing (12 children) - School fees and costs (10 children, 4 adults)
	26. Many children describe their needs in relation to what 'non-caring' children have.	<ul style="list-style-type: none"> • Comparing to other children • Not wanting to stick out 	<ul style="list-style-type: none"> - Relative needs (9 children) - They need help (6 children)
	27. Young carers have a poorer nutritional intake and occasionally struggle to find food.	<ul style="list-style-type: none"> • Lack of diverse foods • Ugali • Impact on the cared 	<ul style="list-style-type: none"> - Diet and Nutrition (10 children) - Food insecurity (5 children, 1 adult)
	28. Young carers frequently suffer from malaria and waterborne diseases.	<ul style="list-style-type: none"> • Malaria • Dysentery • Hospital visits 	<ul style="list-style-type: none"> - Health problems (7 children)
Psychosocial challenges (discussed in Section 4.3.2)	29. Stigma and ignorance causes fear and bullying.	<ul style="list-style-type: none"> • Hurtful words • Being different • Labelled as an orphan 	<ul style="list-style-type: none"> - Stigma (11 children, 3 adults)
	30. Many young carers are worried about those around them and what the future might bring.	<ul style="list-style-type: none"> • Loosing a father is seen as detrimental • Worry about the sick and the future 	<ul style="list-style-type: none"> - Loosing a father (3 children, 1 adult) - Worry (8 children)
	31. Many young carers have already experienced parental death at close hand.	<ul style="list-style-type: none"> • Ailment • Death 	<ul style="list-style-type: none"> - Parental bereavement (7 children, 1 adult)
Managing both education and caregiving duties (discussed in Section 4.3.3)	32. The school performance and attendance of some young carers have been negatively affected.	<ul style="list-style-type: none"> • Lack of concentration • Tiredness • Absenteeism • Busy with home duties 	<ul style="list-style-type: none"> - Caring affects school performance (22 children, 3 adults) - Missing school (31 children)
	33. Many young carers go to school and do well despite their circumstances.	<ul style="list-style-type: none"> • Doing relatively well • Excelling in class • Catching up on work 	<ul style="list-style-type: none"> - Doing well in school (6 children)
Local perceptions of young caregiving (discussed in Section 4.4)	34. Some perceive young caregiving as inappropriate and damaging to the child.	<ul style="list-style-type: none"> • Children should not provide that level of care • Culturally inappropriate • Little time to play • Negative impact on education 	<ul style="list-style-type: none"> - Caregiving detrimental (19 children, 6 adults) - Culturally inappropriate responsibilities (4 children, 11 adults) - Perceptions of young caregiving (4 children, 15 adults) - Play (11 children, 2 adults) - They need help (6 children)
	35. The children have mixed perceptions about young caregiving.	<ul style="list-style-type: none"> • Hard working • Different from other children • Good versus bad 	<ul style="list-style-type: none"> - Self perception (26 children)

4.3.1 Poverty and destitution

As all the children participating in this study live in absolute and dire poverty, their diet and nutritional intake is often inadequate. Many children made note of their undiversified diet comparable to other children and families.

“We may see some people eating chapatti and beans whilst we are eating ugali [maize flour dough]. The following day their diet may change to maybe tea with rice, whilst we have ugali again.” Carolyne, 15 (Mbili/interview)

“I can eat vegetables from the beginning of the week until the end of the week. Now a child also needs other types of food.” Florance, 15 (Moja/interview)

For some young carers, a diversified diet is a luxury and finding food is a problem. Twelve-year-old Kevin for example picks and eats leaves when out of money to buy food. Although the leaves have nutritionally little value and is an indicator of poverty, Kevin is able to see the positives of a satisfied stomach as a result of his active participation.

“I took this photo [see below] because it reminds me of when we have no money to buy food we pick leaves. We cooked and ate them on that day. I took it as a reminder of how they have benefited us. It shows how we managed to get by that day. I ate well and slept well and the leaves sustained us.” Kevin, 12 (Mbili/photovoice, see Picture 12)



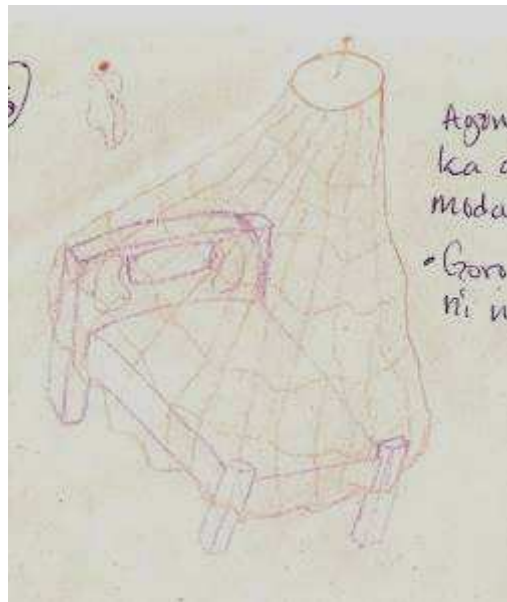
Picture 12: Photovoice picture by Kevin, age 12

The complete and systematic lack of social and institutional support for Kevin, his little sister and his ailing mother, is an example of the kind of destitution in which many young carers live, preventing them from meeting their basic need of food. A couple of children mentioned the nutritional impact of their stay as carers in hospital wards as the environment and circumstances make them lose appetite. This can have a severe impact on children who spend prolonged periods in hospital wards caring for their parents.

“Wards are bad; they are not good places for the sick to be in. Sometimes you don’t eat well and lose weight. You cannot eat while seeing her.” Jael, 14 (Moja/interview)

Poverty also leaves many children without many basic materials. Although having a bed and shoes for school appear to be absolute needs, the majority of needs expressed by the children were repeatedly articulated in reference to what other children have or do and are therefore relative. The children do not want to stand out as poor and many of the needs expressed refer to outward looking and relatively vain materials such as clothes, uniforms and school bags.

“I wish that one day in the future I’ll sleep in a bed similar to the one I have drawn [see below], resting in bed as other children at my age.” Fanuel, 17 (Mbili/draw-and-write, see Picture 13)



Picture 13: Draw-and-write picture by Fanuel, age 17

“The reason why I took this photo [see below] is because it shows things that I lack. I wish I could have things like clothes, shoes, good shelter and even a bag that I can use to carry my books. It is related to me because it affects me. Some children my age are dressing nicely and smart, while I only have two dull pieces of clothes. They carry Safari bags while I carry a plastic bag.” Pascal, 15 (Moja/photovoice, see Picture 14)



Picture 14: Photovoice picture by Pascal, age 15

Relative poverty is also the phenomenon that leads some young carers to mention the poor state of their house. However, the impact of poor housing on education was also frequently mentioned. Leaking thatched roofs makes it impossible for the children to study at rainy nights and mud and dung walls falling apart makes the house breezy and blows out the kerosene lamps or candles used to study.

“I took this photo because it reminds me of that the fact that we don’t have a house and how we lack shelter. The picture is telling us that the house is falling apart. This picture is not good for me and that is the reason why I want to talk about it. If we had good shelter I could be doing my studies without any problems. Because we stay at someone’s house, people around us are talking about us in a bad way. I wanted to share this because if we had a beautiful house we would stay there peacefully.” Debora, 15 (Moja/photovoice, see Picture 15)



Picture 15: Photovoice picture by Debora, age 15

All participating children in this study spend considerable time and energy every day fetching water from ponds and river Yala. The water is often of very poor quality and pond water is often shared with wild and domestic animals that contaminate the water with their faeces. Seasonal droughts force the children to go further a field in search of water. The water is not only used for drinking but

also for watering their crops. Water scarcity and quality is a problem faced by many young carers. In a group discussion young carers were discussing a photo of a water source.

“CA: What is the story behind this photo?

Zeddy: I think s/he took this photo to show that they had a problem of water scarcity in the area so this is the nearest water source they use

Debora: I think this person took this photo because that water seems to be dirty, if we walk or play in it, we can contract diseases such as Bilharziasis. It therefore shows us that children should not play in it.” Young carers (Moja/group discussion)

Although these needs are not limited to young carers they do seem to characterise the deprivation in which they live. Some of the challenges that are characteristic to young carers are psychosocial in nature – something which the next subsection will illustrate.

4.3.2 Psychosocial challenges

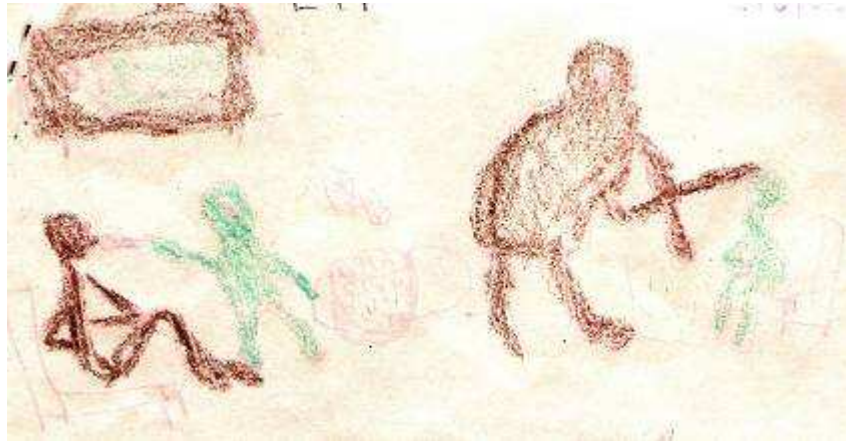
Young carers face a number of psychosocial challenges. These range from lacking social support, caring duties do not give them enough time to play and be with friends, experiencing parental bereavement, being worried about what the future might bring and feelings of fear. Young carers may also experience bullying by other children and abuse and neglect by adults, often as a result of the stigma attached to HIV/AIDS.

Providing care for an adult is not an easy job and many young carers would like to see more support from their environment. Fourteen-year-old Frances for example was asked about how she sees the circumstances of other children providing care and this is what she said:

“I can say that they [young carers] are feeling and experiencing difficulties because attending and taking care of the sick is not a easy job and they should be given support.”
Francis, 14 (Mbili/interview)

Stigma attached to AIDS may also determine the level of social support available to young carers. Fourteen-year-old Pascal was left alone with his ailing father as his mother left the family. Pascal was also unsuccessful in getting support from extended family members and cared for his father until the moment he died.

“I was left alone with my sick father and my father was begging me not to leave him alone. I was told to go and find my mother for support. When I reached, I was chased away by my uncles. This made me really sad. When I got back to my father he was at his last breaths.”
Pascal, 14 (Moja/draw-and-write, see Picture 16)



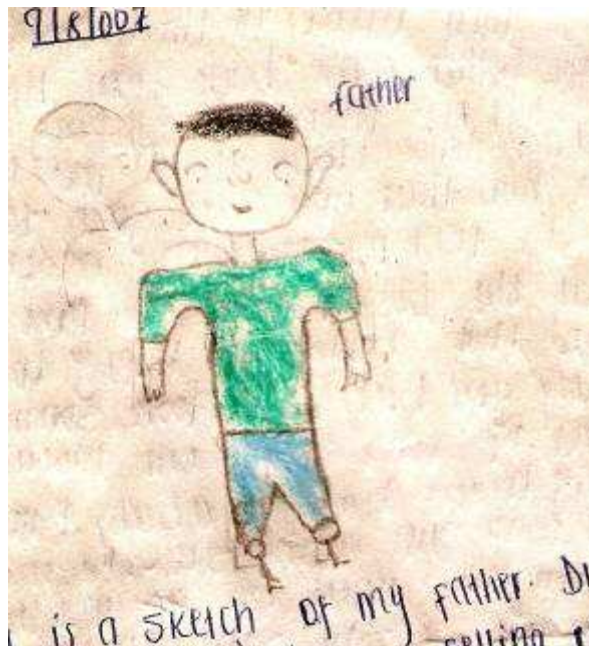
Picture 16: Draw-and-write picture by Pascal, age 14

Whilst some children are without adequate support in their caring role, others, as I will show in Chapter five, are much more successful in mobilising social support networks. Caring duties are time consuming and often compromise the time available for the children to play. Although most of the children do find the time for recreational activities (see Figure 9), 17-year-old Jane expresses the importance of play for children and their self-perception of well-being.

“What do you think about children who are caring for the old?” They are suffering because they are still young, children of that age are still playful and if they can’t play because they are caring, they feel they are suffering.” Jane, 17 (Mbili/interview)

Play and fun also removes the children from the grim reality of parents requiring palliative care or parental bereavement. Witnessing the death of a parent is difficult and requires a period of healing, but due to the nature of HIV/AIDS, many children witness multiple deaths within their family in a relatively short period and have to deal with multiple sorrows.

“My father was admitted to Bondo Hospital where he was for a month before his death. I felt bad hearing the news of my father’s death. He left us with our mother and our grandfather. The death of my father is the one thing that can make me cry. But all in all, God has done well for him, we live with food, but we are ever searching for it [...] my mother got sick and so did my sister. I was the only one who wasn’t sick. My mother became seriously ill and died shortly after [...] I know what death feels like and I feel so bad about what has happened to me in the past.” Florance, 15 (Moja/draw-and-write, see Picture 17)



Picture 17: Draw-and-write picture by Florance, age 15

The insecurity and prospect of staying with a step parent following the death of a parent worries many children. Step parents are known to ignore their step children and favour their own. The children often do not know what the future might bring and this worry can have psychosocial implications.

“There are some men who have two wives and if one dies, she leaves behind her children to the other wife. These children are living with their step mother who is mistreating them [...] My mother is sick, when she is very sick I get really worried as I do not want to be left alone with my step-mothers and it is only when she recovers that I gain strength.” Joyce, 12 (Mbili/interview)

“When my mother was seriously sick; my mind was never settled. I had many thoughts and could even imagine that she was dying. You do a lot of things to keep busy; you eat but have no appetite, at times you don't feel like eating so you feel you should always be near her doing everything she wants doing. You are not settled at all and think she may die should you move away from her. That is not a good life at all.” Debora, 15 (Moja/interview)

Another worry haunting some young carers is the fear of contracting AIDS. Stigma and lack of knowledge led 17-year-old Jane to fear of touching her own mother as she got sick.

“When I first started caring I found it difficult. At first, I even feared touching her.” Jane, 17 (Mbili/interview)

Young carers may not only face stigma and fear of AIDS within their own home, but also on the playground in their school. One such experience is shared by 14-year-old Everline who has experienced the cruelty of other children commenting and making jokes about her bedridden

parents. Interestingly, Everline talks about the other children as ‘non-caring’, distinguishing herself as the other (young carer).

“I sometimes do not go to school; some non-caring children talk bad about me. They joke about the conditions of my parents.” Everline, 14 (Mbili/interview)

Hurtful words not only come from children, but also from their guardians. One adult notes that it is common for some guardians not to acknowledge the support they receive from children to other adults and at the same time feed the conception that orphaned children are a resource-consuming burden.

“Sometimes a child prepares food for a sick guardian and gives it to her, but if someone walks in, the sick will say that the child is the one eating all the food without sharing it. This a child cannot forget.” Female adult4 (Moja/interview)

This subsection has brought forward some of the psychosocial challenges children may face during their time as carers. Many of these challenges can be overcome through enhanced social support and the provision of medicines to those old or ill in an attempt to prolong their life and well-being.

4.3.3 Managing education

As Figure 9 outlined on page 135, education takes up a large portion of their time. Their commitment to education signifies the importance of it to their lives. Education gives them a break from duties, gives them time with peers and is perceived to be the only way out of poverty, serving as a source of hope for the future.

“I drew this picture of a school because I like education and would wish I could go back to school in the future. This drawing shows and reminds me that school is very important and I would wish I could go back to school... if God is willing. Education is good and can bring about change in my life and in my community.” Jane, 17 (draw-and-write)

However, managing their commitment to education with caring responsibilities can be a challenge for many young carers. As illustrated in Table 16 many children spoke of how their caring experience have affected their school attendance and performance negatively. Many young carers will at some point have taken time out of school to provide care for someone. Not only does this compromise their learning, but also their relationship to the teachers who in rare instances (like that of Debora) were not empathetic about their circumstances. Many children reported having to repeat classes as a result of their absence.

“What stays in my mind and makes me sad to think about is the time when my mother was seriously sick. I used to stay with her; it was difficult for me since it was on school days, people were going on with learning at school and I had to miss out. I had no permission to

be out of school and the teachers did not understand my problem and duty of taking care of my sick mother. It was so painful for me to miss school.” Debora, 15 (Moja/interview)

“When I went back to school, the caring experience forced me to repeat class two.” Pascal, 14 (Moja/interview)

It is not only the provision of nursing care that forces some young carers to temporarily drop out of school. Those with added income generating responsibilities may drop out of school seasonally to harvest or simply when money has run out or if school fees and medicines need to be paid for.

“I do well in school but at times due to lack of fees, text books and duties at home I am sometimes not performing well because it forces me to be out of school for some time, this affects my performance negatively.” Francis, 14 (Mbili/interview)

“Children who provide care cannot settle well in class since they are the ones attending those who are sick and the old. They cannot concentrate well in class and that makes them perform poorly [...] children who do not provide care, are going to school well. They can concentrate in class since there is nothing disturbing their mind but us who are caring for the old and the sick, our minds are preoccupied and cannot fully concentrate in class. Non-caring children are not indulging in hard work such as burning charcoal. O.K. they can practice it for leisure whilst we must take it seriously, knowing very well that it is a source of income necessary to help the sick.” Syprose, 14 (Mbili/interview)

As Syprose hints, absence does not only have to refer to physical absence but can also refer to mental absence. A number of children mentioned a lack of concentration in school as a result of their worries and fears for their sick parents and what the future might bring. Most of the children speaking of their inability to concentrate in school did so in past tense, indicating that it might just be a phase can be overcome.

“What I went through at that time, changed my life to the worse, at that time when I went to school, I could not concentrate in school since I have sleepless nights, I did not do well in school work.” Pascal, 14 (Moja/interview)

“Even when I was in school I kept on thinking about what has happened to my life. At times I could think so deeply that I found myself crying in class. I could not study well, instead of studying I thought of my responsibilities with the grandmother.” Edith, 17 (Moja/interview)

Although some children claim their school performance has persistently deteriorated since they took on caring responsibilities, many young carers go back to school and do exceptionally well.

“In September when the school reopened, I missed school; my fellow children were going to school as I stayed at home caring for my sister. I continued doing this up to late October, four weeks to closing. When I joined school then, our teacher asked me where I was. I told the teacher of my sister’s sickness as having made me to be out of school. The teacher encouraged me to study hard since I had missed a lot. This was a week to the beginning of

exams. I studied and prayed and managed to be position 9 out of 48; I managed to perform well despite the fact that I only studied for 4 weeks out of 14 weeks in a term.” Austine, 14 (Moja/essay)

“How are you doing in school? In class my performance is not bad at the moment. I have managed to catch up with work unlike in the past where I was thinking of the sick. I have managed to catch up well even the district exams that we did recently, I got over 60% in mathematics but when my father was sick and I was caring for him like feeding him; giving him what he wanted; it was in term three, was shocked and got below 60% marks but I managed to pass the rest of the subjects; though my average marks was below what I expected but now I am doing well.” Edith, 17 (Moja/interview)

The ability of many young carers to bounce back and climb up their school performance rank is an indicator of the resilience many children muster. Dropping out of school for a year to provide care for ailing or ageing guardians, does not have to be detrimental to the child's school performance in the long-term. Because caregiving may come with a high cost at one point in time, but fade away with increased resilience, perceptions of young caregiving differ according to what time or moment they refer to when describing their experiences.

4.4 Local perceptions of young caregiving

It is no surprise that there is a mixed bag of local perceptions of young caregiving, both by the children themselves and by adults in their communities. Children's self-perceptions of caregiving may be dependent on their experiences and what stage they are at in their journey as carers. The methodology used and their perception of the interviewer might also determine the self-perception which they communicate by giving desirable and strategic answers. Adult's perceptions, as we saw in the beginning of this chapter, depend very much on how they perceive childhood. A complex network of variables, many of which have been introduced in this chapter, influence the way in which young carers are perceived. This section draws on the themes 34 and 35 as outlined in Table 16, looking briefly at how young carers see themselves or other children with caring responsibilities and how adults describe the circumstances of young carers.

4.4.1 The self-perceptions of young carers

Some young carers perceive children who are in similar circumstances to themselves, as suffering.

“I drew this picture to remind me of the kind of help I offered my grandmother. Our grandmother has been sick for quite some time and it is me who has been helping her out. Even when my mother was sick, she was also sick and I cared for both of them, so I have always been suffering, nothing to be proud of.” Jael, 14 (Moja/draw-and-write, see Picture 18)



Picture 18: Draw-and-write picture by Jael, age 14

"A child with parents leads a good life whilst a child who is an orphan may not lead a good life. Why does a child without parents lead a bad life? S/he could be staying with a person or a relative who may be giving him/her heavy duties; could be staying with an old person that he/she is the one who cares a lot, so s/he is struggling with duties. Sometimes it is the child who must ensure that food gets on the table." Debora, 15 (Moja/interview)

However, it appears that many children are split and attach different meanings to their caring experiences. Michael, for example, illustrates this well by arguing that young carers may feel overworked, but at the same time volunteer to do so for reasons I have already discussed in Section 4.2.1. He usefully distinguishes between work and care.

"Children providing care are working too much and yet she knows that she is caring. So you may say that so and so is overworked and yet s/he volunteers to do so and knows that s/he is providing care." Michael, 15 (Mbili/interview)

This split of self-perception can be further exemplified by looking at the accounts of 15-year-old Carolyne. Using different methodologies and over time, she attached two different meanings to her caring experience. The first meaning was negative and articulated in an interview.

"The life of young carers is not good because sometimes the grandmother is sick, you wash her, you fetch water, and you cook for her. In fact you are so committed to caring that you do not have time to rest. Sometimes you see other children rest while you can't because of the workload. The life of caring children is not good because they are overworked and have little time for rest." Carolyne, 15 (Mbili/interview)

Nevertheless, when Carolyne was asked to reflect more directly upon her own experiences as a carer she managed to draw on some more positive elements of providing care. Following her description of the things she had to do for her ailing mother, Carolyne concluded that it was worth it.

“I was with my mum at home until her death. In my life, I think all these I did were important and good.” Carolyne, 15 (Mbili/essay)

Carolyne has effectively had two different experiences and versions of what it is like to be a carer. Interestingly, Carolyne's caring experience and meaning of caring was influenced by whom she was caring for. Her negative associations for care were described in relation to her experiences caring for her grandmother, whereas her more positive associations with care were in relation to the care she provided for her mother until her death. The work/care split is therefore influenced by the emotional bond between the carer and the cared-for.

Like Carolyne, many young carers felt that caring is a good thing to do and would therefore recommend other children to provide care.

“I think and feel that it is good to help sick and old people and it needs heart and love. Now I'm confident in assisting people even our mother whom I can't fail to care for. I think and wish that children should care for such people.” Mercy, 12 (Mbili/essay)

One of the benefits of providing care is how adult community members perceive children who help out. In the beginning of this chapter I uncovered that children helping out at home are considered 'good children' in Luo society. Young carers are therefore loved by family and community members for their extraordinary responsibilities.

“I took this photo [see below] because the mother in this picture is a widow. She is the mother whom I am always taking care of. I always fetch water and collect firewood for her during my leisure time. The photo is connected to me and my community because I am loved by everyone in the community.” Catherine, 14 (Moja/photovoice, see Picture 19)



Picture 19: Photovoice picture by Catherine, age 14

4.4.2 Adult perceptions of caring and working children

Like the children themselves, adults in the community communicate different perceptions of young caregiving. In accordance with my observations, children were generally perceived to be a valuable asset to the household economy because of their help and role in sustaining households. As one adult expressed earlier: "A child is the wealth of the house." The role of children as 'helpers' reflect the expectations of adults in an impoverished setting.

"In our Luo culture, a child must go to the garden. In Luo land, if you don't work hard, you will not get anything to eat." Female adult6 (Mbili/interview)

As highlighted in the beginning of this chapter, traditional expectations of children are increasingly under pressure, due to contemporary expectations such as the need for education, which has become more and more accessible to children from rural communities. An adult from Moja community reflects on this dilemma of traditional and contemporary expectations of children.

"A child does cook, even when they are still young, but the child should not. We just expect them to do it, but they should not. Some parent's make their children work around the clock and this makes them unable to study." Adults11 (Moja/group discussion)

The contested and different meanings associated with caring or working children means that the representation of local childhood, which children like Catherine (above) draw on to make sense of her duties, does not always match what the adults articulate in an interview. Many adults would still argue that caregiving by children is detrimental to their well-being.

"The [caring] child will suffer; just like the sick one [...] Children in these circumstances are suffering." Male adult1 (Moja/interview)

Such responses may, or may not, be influenced by the fact that an NGO and a Caucasian are involved in the research, both of which are perceived to be a route for financial and social support and are therefore providing desirable answers.

Conclusion

This chapter has explored experiences that constitute the 'otherness' of 'other childhoods' and so examine the 'un-childlike' issues of young carers in Bondo. In answering the two research questions set forward in the introduction of this chapter viz.: (i) what is the nature of their caring roles and responsibilities? And (ii) what are the psychosocial needs of young carers in Western Kenya? – a number of interesting findings emerged. To understand the nature of children's caring roles, I first set out to explore the local context in which young caregiving takes place. I found children's work and household support to be an important cultural characteristic, something which many adults drew on when explaining or justifying young caregiving. These meanings, coupled with the socioeconomic and familial circumstances of the household, determine the complex relationship between children and adults. For most guardians, the children were perceived as an asset, where

children, driven by love, provided their guardians with nursing care and subsistence support. Following the death of their parents, many children continued caregiving, but this time for ailing or ageing family members, a relationship which gets increasingly transactional as they move beyond their ancestral and clan members where children care in exchange for fosterage.

Although foster parents are as much in need of care and support as the children they foster, the relationship stays hierarchical, with adults being the powerful 'other', as a result of the language and representations that characterise children as 'helpers' and adults as figures who shape and discipline children into responsible citizens. Children were acutely aware of these representations and made every effort to please their foster parents by providing them with as much care and support as they possibly could.

These structures allow children to move between stages of care. They might be sent to their ageing grandparents and help them with day-to-day duties as they weaken. Once they die, the children return to their parents who one-by-one get ill and require nursing care such as washing and feeding their parents, administering medicines and care for younger siblings. If there are little or no financial and social resources available, the children may also engage in income generating activities to feed the household. As the parents die, the children move in with foster parents or grandparents, many of which are ageing and require nursing care. A minority stay with middle-aged foster parents who use the children as servants, contributing significantly to the household income and child care. Figure 10 seeks to summarise thematically the key findings discussed in this chapter.

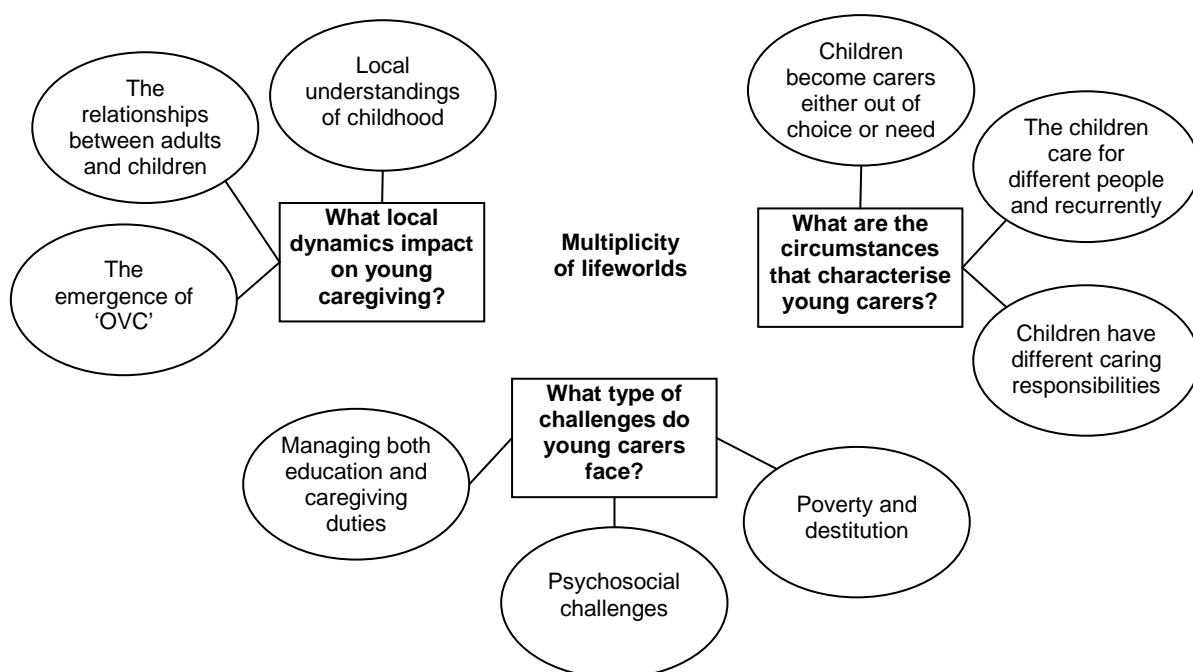


Figure 10: Summary of the multiplicity of lifeworlds that characterise young carers

Figure 10 seeks to summarise the thematic content of this chapter. However, to fully appreciate this rather simple summary, one must understand the heterogeneity of the young carer phenomena. Whom, how long and how many they have cared for, coupled with the socioeconomic

circumstances and other ecological influences all impact on the child's psychosocial well-being and ability to cope. Different dimensions of young caregiving must therefore be recognised and diverse local understandings and experiences young caregiving require greater international attention if we are to understand their psychosocial well-being.

I would like to conclude this chapter with an illustration of the socioeconomic determinants that impact on young caregiving and highlight the continuum of care which lead many young carers to go from one caregiving experience to another (see Figure 11). Most children have their first caring experiences with their siblings, and as their parents fall ill, a succession of caring experiences often follow. The vulnerabilities young carers experience at each step of the continuum differ and the social and psychological coping resources available to the children also differ from step to step (and indeed within each step), indicating that vulnerability and coping are both fluctuating processes influenced by their individual, familial and social environments rather than static experiences.

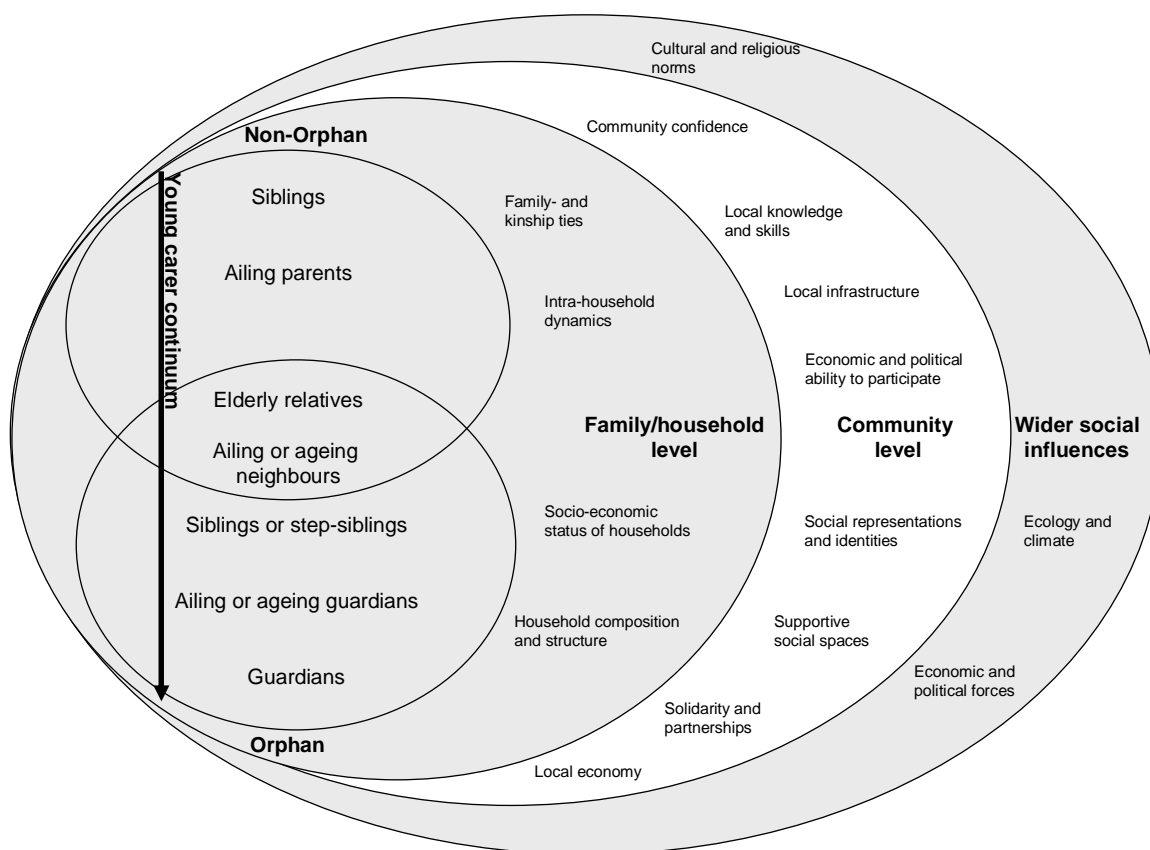


Figure 11: A young carer continuum within an ecological system

However, what transpires from the circumstances of young carers outlined in this chapter is that they are often living in conditions of poverty and within a cultural/symbolic framework that devalues young people and leave orphaned and caregiving children vulnerable to discrimination and abuse. Despite their vulnerability, many young carers show resilience by doing well in school and by focusing on the positive outcomes of being a young carer. The meanings and relationships discussed in the chapter form the foundation for the forthcoming chapters on the coping strategies of young carers.

Chapter 5 - Social coping strategies

Introduction and chapter overview

The previous chapter discussed the complex circumstances of young caregiving; the diversity between children's experiences and within individuals' own caregiving experiences. The chapter provided us with background to some of the social forces that impact on the lifeworld and well-being of young carers. In doing so, the chapter confirmed the importance of looking at the circumstances of young carers within their social environment, an environment mediated by resources and social relations, or lack thereof, at both an individual, familial and community level.

Against this background this chapter sets out to explore the social resources potentially available to young carers that can facilitate coping. To fully comprehend this chapter, the findings presented must be understood in relation to 1) the problems they face and 2) local understandings of childhood. Both the impact of poverty and local understandings of childhood have been discussed in Chapter four which also provides some background to understanding why children's participation in community life is important to promote their own well-being and that of others. This chapter seeks to explore this process further, looking more specifically at the strategies and resources available for some young carers to actively draw on in difficult circumstances. This chapter not only highlights the social resources that the majority of young carers refer to, it also discusses how these social resources benefit them, how they make sense of them, and where possible, how they have actively negotiated this level of support. Situations where children have been unable to negotiate and access adequate support will also be presented.

Reflecting the thematic network presented in Table 17, this chapter has been divided into four sections, each representing different levels of analysis in the ecological model presented in the final section of Chapter four. This distinction between levels of analysis should not be taken too literally due to the cycling and use of resource across the levels. The first two sections will present findings at a community level, with the former looking at the interface between wider social influences and the community and the latter focusing on relations at a community level. The third section explores intra-household dynamics, looking at the role of immediate and extended family members in providing support to young carers. The fourth and final section explores the competence and agency of young carers as they take matters in to their own hands and engage in food- and income generating activities.

Table 17: Global theme: The social coping strategies of young carers

Organising themes	Basic themes identified	Issues discussed	Codes
Community structures (discussed in Section 5.1)	36. The school gives young carers a sense of normality.	<ul style="list-style-type: none"> • Being with other children • Aspirations 	- School, a place of joy (5 children)
	37. Teachers can be an important source of encouragement and support.	<ul style="list-style-type: none"> • Teacher support • Encouragement 	- Schools supportive (10 children, 3 adults)
	38. Children draw on faith and spiritual resources to give meaning to their circumstances.	<ul style="list-style-type: none"> • Serving God • God recognises your work • Faith 	<ul style="list-style-type: none"> - Blessings by God (11 children, 1 adult) - Spiritual support (8 children, 1 adult)
Community support (discussed in Section 5.2)	39. Children can negotiate support from community members.	<ul style="list-style-type: none"> • Provision of meals and clothes • Empathy • Neighbours • Access to land for farming 	- Community support (31 children, 6 adults)
	40. Community based organisations and grassroots groups are a source of support for many children.	<ul style="list-style-type: none"> • CBOs • Home based care groups • Faith based groups • Widows group • 'Harambee'/fundraising • Meals, clothes and fees 	- Community support groups (9 children, 10 adults)
	41. Notions of unity and togetherness, materialised through peer-led group support.	<ul style="list-style-type: none"> • Mutual support • Encouragement • Empathy and emotional support 	<ul style="list-style-type: none"> - Togetherness and unity (5 children, 1 adult) - Peer support and friendship (16 children)
Family support (discussed in Section 5.3)	42. Members within households and the immediate family often share responsibilities in caring for the sick.	<ul style="list-style-type: none"> • Siblings share duties • Collective effort 	- Sharing (10 children)
	43. The extended family steps in and support children when the immediate family is unable.	<ul style="list-style-type: none"> • Relatives have the primary responsibility • Aunts and uncles • In-law families • Gender differences 	- Family support (35 children, 6 adults)
Active engagement through agriculture and income generating activities (discussed in Section 5.4)	44. Many children benefit from keeping animals.	<ul style="list-style-type: none"> • Important source of milk and eggs • Animals can be sold • Offspring give hope • Animals an insurance during times of hardship 	<ul style="list-style-type: none"> - Benefits from livestock (23 children) - Benefits from poultry (13 children)
	45. Fruit trees and cultivation of gardens provided the children with an income and food.	<ul style="list-style-type: none"> • Vegetables can be sold and diversify diet • Growing (nutritious) food • Fruits can be sold or eaten 	- Benefits from gardens (46 children, 1 adult)
	46. Boys often engage in charcoal burning and work for neighbours in hope for reciprocal support. 47. Girls sometimes do domestic work and sewing for neighbours.	<ul style="list-style-type: none"> • Income generation and meeting basic needs • Charcoal burning harmful to health • Good money 	<ul style="list-style-type: none"> - Charcoal burning (17 children, 1 adult) - Income generation (19 children)

5.1 Community structures and wider social influences

As the ecological model (see Figure 11) presented in Chapter four indicates, wider social influences can impact negatively on the well-being and coping of young carers. Inflation, droughts, a lack of social security and hierarchical and exploitative relations between children and adults are only some of the economic, political, climatic and cultural factors that increase the vulnerability of young carers. Nevertheless, some wider social influences can also present protective and supportive factors that can facilitate coping at a community level, some of which will be outlined in this section.

With free primary education, an increasing number of Kenyan children enjoy the benefits of going to school. The demand for education has meant that more and more primary schools are being constructed in consultation with their respective communities. The increased access to schools and teachers may present a potential protective factor as the young carers negotiate for support. Twelve-year-old John from Mbili community, for example, states that:

“Children can go to the school and ask the teachers for support, who will see what they can do for the child.” John, 12, (Mbili/interview)

John expresses confidence in the approachability of teachers and their capacity to help, and more importantly, he notes the active role of children seeking support by simply asking. Children from both communities spoke of their schools as an important space for developing bonding friendships, and school was also seen as a place of hope, helping the children believe in themselves and the future. As articulated by 17-year-old Carren, schools can also give young carers a sense of normality and stability amidst difficult circumstances.

“When I am in school, sometimes I sit and think back of how things are at home. I enjoy being in school like the other children.” Carren, 17 (Mbili/interview)

However, the level and type of support provided by the schools differed significantly between the two communities. Nearly half of the children from Mbili found their teachers to be understanding and supportive of their circumstances, whereas no children from Moja reported receiving support or advice from their teachers. In Mbili, the school was frequently said to be a place that acknowledged the circumstances of many caring children and showed them flexibility and support.

“The teachers were encouraging me a lot; they also visited me at home. They encouraged me to assist my mother, told me that I could always repeat the examination and should take care of her until she felt better.” Everline, 14 (Mbili/interview)

The understanding and empathy that teachers from Mbili show plays an important role in giving the children some peace of mind. Some teachers were identified to show their understanding of children’s circumstances by relating their teaching to the local environment and the local resources

available to the children, in order to develop the children's local knowledge and skills to cope with their difficult circumstances. Again, 12-year-old John from Mbili community is particularly fond of the support he can access from individuals within his school. John describes how one teacher spends time after school and during holidays teaching children vocational skills that can help the children generate resources to cope with difficult circumstances.

"I would like to talk about this photo because it shows my teacher. Our head teacher is a very kind and good man. He encourages us in everything, encouraging us to learn and be hard working. One of the activities he has been talking about is charcoal burning and tree conservation when we are off on holidays. These activities help us to raise funds for example shoes, books, pens and many other items. His teachings have made many people learn how to burn charcoal which has helped youths a lot." John, 12 (Mbili/photovoice, see Picture 20)



Picture 20: Photovoice picture by John, age 12

As previously said, no children in Moja community reported on support and empathy from their local school, possibly because the school leaders and the teachers place much emphasis on education, neglecting their empathy and understanding for what is happening in the lives of young carers. However this needs to be explored further. Although schools have the potential to be supportive, this is not always the case. On the contrary, schools can also be a source of stress and unhappiness when caregiving is seen to compromise school performance and attendance, in fact, the impact of caregiving on schooling was a source of the majority of negative meanings that children from Moja ascribed to caregiving.

"The truth is that caregiving was not my wish; if I could decide it would not be me but a parent or someone who has completed his/her education that should care. It interfered greatly with my studies; instead of proceeding, teachers wanted me to repeat. I lost a lot of time while caring; there are no exams on caregiving." Edith, 17 (Moja/essay)

Although there are no exams on caregiving and local knowledge, the informal socialisation of children combined with their responsibilities and experiences provide young carers with local

knowledge that helps them make decisions and execute activities that optimise their ability to cope. One example of useful local knowledge is that of animal keeping as demonstrated in a group discussion between boys from Mbili community. Here the boys discuss a picture of a cow, photographed by one of them. Besides analysing the condition of the animal in great detail, the reference points used imply they all share this type and level of knowledge – exemplifying the importance of local knowledge as part of their coping.

“What do you think is the story behind this photo?” *Fanuel*: The cow has been tied as if it is about to be killed though I don’t see the items for slaughtering it around there. It also seems to me that maybe the cow was sick so they want to save her life and it looks like the cow is suffering from some disease. *Kevin*: Since I know and usually look after the cattle, it seems that the cow is about to be injected, I think that person is looking and trying to locate the right place to inject the cow so it can heal. Don’t you my friends see the bone of this cow protruding or am I getting it wrong? [Everybody laughs].” Young carers (Mbili/group discussion)

Whilst this knowledge may not be unique to young carers, but something which children in this rural area are raised to know, this local knowledge, combined with technological advancements, such as vaccinations against animal diseases, have helped young carers cope with their circumstances. I will return to the importance of animal keeping in Section 5.4. Also increasing exposure to affordable and accessible modes of transport were frequently mentioned by the children as an important mean to cope with their duties. Those who had access to a bicycle spoke of the increased efficiency of using a bicycle in terms of time saved and the volume that can be carried on it.

“I want to talk about this bicycle because it helps me in many ways, like fetching water for our house and for my other grandmother who is unable to fetch water by herself. Others can also ask for it as they need to do journeys. It assists the community a lot because it makes hard jobs easier. It allows you to carry more weight, and it can take you to places you cannot walk to.” Edith, 17 (Moja/draw-and-write, see Picture 21)



Picture 21: Draw-and-write picture by Edith, age 17

Bicycles, as an affordable means of transport, have not only made life easier for some young carers; they have also allowed them to reach areas that were previously inaccessible because of

the distance. They can now take their produce to more competitive market places and fetch water from more distant water sources when local sources are dried up.

Churches and faith-based groups were also mentioned by many children as a source of support. A number of children took a photo of their local church, describing how their Church had helped them with school materials, food and psychosocial support. Sharon, age 15, who is staying with her grandmother, even got their house from the Church: "The house was a gift from the local Church." The children also actively draw on the role of faith in order to cope with their circumstances. Many children believed that 'God gives answers and is always there' for them, providing them with tranquillity and hope.

"It has helped me to know that God can help you in different ways. For example sometimes I receive help that I did not expect." Syprose, 14 (Mbili/interview)

The faith and spiritual support from God also helped some young carers cope with bereavement and difficult circumstances. Fifteen-year-old Florance, for example, feels let down by everyone as those whom she loved died one after another. She now feels that God is the only one by her side whom she can trust not to die.

"I looked after my sister for six months and spent a lot of time in the hospital. One day at home, after she had been released from the hospital, I was preparing tea to drink and when I was going to take sugar I found my sister dead. I dropped the sugar I was carrying. Nothing can explain how I am feeling, first my father died, then my mother and now my sister. I have been feeling so bad until now and God is the only one I can now trust." Florance, 15 (Moja/draw-and-write, see Picture 22)



Picture 22: Draw-and-write picture by Florance, age 15

Aside from depicting the importance of God in the lives of many young carers, Florance's story also indicates some of the emotional and psychological challenges that children face following numerous bereavement experiences.

This section has demonstrated how aspects of the national economy (affordability of basic transport), policy (free primary education) and religious norms (churches and faith-based groups) can interact with the lifeworlds of young carers at a community level. Young carers actively draw on local knowledge and skills and benefit hugely from the increased availability of bicycles (following affordability and increased imports) and means of affordable public transport. Educational establishments provide many young carers with psychosocial support through those teachers who empathise and consider the circumstances of young carers and pass on local knowledge and skills that can help them cope. Whilst this was reported by nearly half of all children in Mbili, no children from Moja reported their schools to be supportive. This section also illustrated the importance of churches and faith-based groups in the provision of support, giving an example of the complex interaction between the different levels that make up the lifeworlds of young carers. These community structures (e.g. schools and churches) interact through teachers, church members and faith-based groups (community level) in dialogue with the children who give meaning (individual level) and are active recipients of support as they listen, engage and interact with teachers and church members. The next section explores some of the protective factors and coping strategies evident again at a community level, but focuses on the more informal structures and networks.

5.2 Community support and cohesion

The social cohesion found at a community level is at the core of this thesis. As highlighted by Table 17, this section outlines some of the social psychological resources and factors at community-level of analysis that facilitate coping and contribute to the psychosocial well-being of young carers. These resources are mediated and influenced by wider social influences and the circumstances that characterise the children at an individual, familial and household level.

One important social psychological resource is the solidarity and connectedness that seems to characterise relationships within their communities. Many community members acknowledge their role in supporting the less fortunate and needy children. When asked about the potential sources of support for young carers, an adult from Mbili answered: "If a child is living with an old person and struggling, I can buy him or her clothes because I know that s/he is suffering. It also means that if I do that, God will bless me." With many community members showing solidarity and being willing to help vulnerable children, it is not surprising that many of the children report neighbours and community members to be a source of support, particularly when it comes to giving them food and school materials.

"If I have no food, I get it from the neighbours." Kevin, 12 (Mbili/essay)

"Even your neighbour can give you flour to prepare porridge for the ill." Beryl, 14 (Mbili/interview)

However, accessing support from community members rarely comes without some kind of negotiation. The negotiation can take many different forms. For example, children can actively draw on local representations of vulnerability and poverty and project themselves as poor in order to access support. Such a strategy has been described by 12-year-old Mercy from Mbili, who explains what effect wearing torn clothes can have:

“Some people buy you clothes because they see you wearing clothes which are torn. When they see you like this, the community/village can buy for you clothes with the money they have raised.” Mercy, 12 (Mbili/interview)

One of the dangers of such negotiation is the victimological representation the children take on. This is also illustrated by 12-year-old Joyce who in her negotiation for support identifies herself as one of the vulnerable children, aware of how the appearance of looking hungry and poor can earn her and other children support.

“If we do not have clothes there may be others who can buy it for us. There are some parents who are very generous and when they see you hungry, they give you food.” Joyce, 12 (Mbili/interview)

Children were also found to project their needs explicitly to community members by talking about their circumstances in the hope of winning sympathy that translates into support. For most children however, support requires some sort of reciprocity of favours. Twelve-year-old Kevin illustrates this well by describing how he gets food from his neighbour, in return for his labour in weeding and harvesting their shamba (piece of land used for subsistence farming). By working their land and giving them some of the harvest, Kevin gets access to land and food that he otherwise would not have had.

“In our community we share and help one another. If I have no food, I get it from the neighbours and in return I assist them in harvesting maize, sorghum and beans.” Kevin, 12 (Mbili/essay)

The reciprocity that characterises many of the relationships can be less implicit and work on an emotional level, often in the shape of friendship. Fifteen-year-old Ben gives an example of this type of reciprocity as he describes a photo of a family friend.

“I want to talk about this photo [see below] because this mother is a good friend and my mum’s best friend. I really enjoyed taking a picture of her. After taking the photo of her she told me to go to hers to get a goat on my own. She gave me a goat and ‘simsim’ (sesame seed sweet). I thank God and pray she will be blessed in whatever she does. This photo reminds me a lot about what this mother has done to us and others.” Ben, 15 (Mbili/photovoice, see Picture 23).



Picture 23: Photovoice picture by Ben, age 15

In this example Ben, through this research project, had access to a camera and decided to take a photo of a woman who has helped him a lot, with the result that he was given a goat. It is possible that through this exercise Ben got a chance to articulate his appreciation to this woman, who in return provided Ben with further support. Although Ben could not have known that he would have been given a goat in return of taking a photo of his friend, he most probably knew that in taking the photo, he would nurture, as part of his negotiation for support, their relationship.

A more implicit strategy used by most of the children in conjunction with the less direct negotiation of support (as seen above), is to simply ask for support. This type of support is typically less conditioned by reciprocity, however it can rest on a long-term relationship in which the children has previously, or will in the future, benefit the community member providing support. Numerous children mention in passing how they can go to their neighbour or other community members and ask for the things they need.

The photo reminds me of the kind of support and love we get from the community members. If I need anything, I tell them and if it is available, I will get it." Carolyne, 15 (Mbili/Photovoice, see Picture 24)



Picture 24: Photovoice picture by Carolyn, age 15

Another more direct type of support usually takes place through a ‘Harambee’ (Kenyan tradition of community self-help events) in which vulnerable children receive support from groups or networks of community members. Harambee literally means working together for a common purpose, reflecting solidarity and connectedness, and it forms the foundation for the many community and grassroots groups that fill the social landscape in Bondo. This study suggests that Harambee is a tremendously beneficial tradition that supports children and other vulnerable members of their communities. Reflecting on Harambee, one social development professional recommended people to work together for a common cause: “when a family, a community or a group is facing problems, they should establish a group. A group can find a way of solving problems.” Both adults and children reported on the benefits of community groups for vulnerable children. One female member of a community group stated:

“When we started our group, we brought a number of children together. We are providing them with meals and this enables them to concentrate in school.” Female adult10 (Mbili/interview)

Another woman in a group discussion declared the need for young carers to be supported through Harambees and suggested that church members and community health workers (CHWs) would be the best people to support young carers.

“Someone may be cared for by his/her child. In such cases church members can support the child. Community Health Workers can also support the child; sometimes the sick person is under a certain home based care programme, so the health worker can support the child.” Adults11 (Moja/group discussion)

Children from both communities benefited from local community-based organisations (CBOs). Bondo district has approximately 3,500 registered CBOs, some more active than others. The CBOs are established by groups of local residents who seek to carry out social work for members of their community. To get registered as a CBO with the DGSS, the group must have a committee, or a board of trustees, that take responsibility for the running of the CBO. The CBOs in Bondo cover a whole array of issues, from the rights of fishermen, to youth sports clubs and widows and women's groups providing home based care or orphan care and support. The vast majority of CBOs are self-funded and raise funds via Harambee (asking community members to donate money or other social resources). Some of the more successful CBOs are picked up by international NGOs who build the capacities of these CBOs and provide them with the resources and skills (e.g. training and drugs for home based care) to increase their reach and impact. Many CBOs apply for funds from the local constituency development fund (CDF), a scheme whereby the Government of Kenya supports community initiatives that aim to improve community infrastructure and services. The two CBOs operating in Moja and Mbili both co-ordinate health related activities and mobilise support networks in their communities. The CBO in Moja receives support from various NGOs through extensive training programmes, provision of food supply and drugs, running a successful home based care programme in which the CHWs are HIV positive themselves. The CBO in Mbili had not yet attracted NGO funding (that is until the intervention with WVP Kenya), but received a small grant from CDF to create awareness of HIV/AIDS in the community and mobilise social networks. This has been noted by 15-year-old Michael from Mbili community who expresses his gratitude and endorsement for the local CBO, which has created a social space which has removed the fear of speaking about HIV/AIDS as well as the stigma associated with those affected by the disease, allowing people to act and support those infected.

“The Mbili Group has improved our health services and encouraged better hygiene and they have helped the people with HIV/AIDS in many ways. In our community they are great to us and we love them so much. I love them for the way they act towards us. They have improved the living standard of my life.” Michael, 15 (Mbili/essay)

The benefits of the home based care programme in Moja community were also expressed by the children in this study. The CBO, with assistance from international NGOs, had mobilised and trained CHWs to provide care and support for those bedridden and in need of palliative care. The majority of CHWs in Moja are women and HIV positive themselves. Although there are many benefits to having a CHW who is HIV positive (e.g. their understanding of the disease and the impact it has on their lives), a limitation is their fear of contracting opportunistic infections in the course of their nursing duties. So although 17-year-old Edith and her bedridden mother receive psychosocial support from HIV positive CHWs, their fear of contracting cholera limited the support they could give to Edith and her mother.

“I was just alone with some women from our community who came to see my mother. But they could not touch her arguing they could contract cholera.” Edith, 17 (Moja/interview)

The strong community ethic and Harambee which often makes support available to children during times of hardship also shapes the way in which the children themselves articulate a strong ethic of responsibility to care for those in need of support. This is well articulated by 15-year-old Carolyne:

“I want to talk about this photo as this woman helps those children who cannot get certain things and those who are old and sick. This photo shows that we should all join hands and help the old and the sick.” Carolyne, 15 (Mbili/photovoice, see Picture 25)



Picture 25: Photovoice picture by Carolyne, age 15

As articulated by Edith, there are limitations to the support made available by grassroots groups. Community support was not available to all the children and could be constrained by external factors such as stigma, inflation or drought. This is further expressed by 15-year-old Janet who describes a photo of her ailing mother preparing leaves (Black Night Shade/*Solanum americanum*) which Janet had picked from a bush.

“This photo reminds me of how we can get through difficult times with food shortage and when there is nobody to welcome you for dinner.” Janet, 15 (Mbili/photovoice, see Picture 26)



Picture 26: Photovoice picture by Janet, age 15

Stigma of HIV/AIDS left some families with little support. When describing a photo of her house, 14-year-old Jael noted that nobody helped her and her ailing mother when their thatched roof needed changing, an activity usually supported by community and clan members.

“My father died on Friday the 5th of May 1996 and he left us in this thatched hut. When time came for changing the roof of our hut, there was no one to help us bringing in the grass from where it was cut.” Jael, 14 (Moja/draw-and-write, see Picture 27)



Picture 27: Draw-and-write picture by Jael, age 14

Despite, or perhaps because of, these limitations to support, some children, with adult guidance, set up groups and clubs aimed at helping one another. Inspired by what can be achieved as a group, some children set up their own support groups. Fifteen-year-old Millicent describing a photo of her friends says:

“I want to talk about this photo because these school children have formed a group which I am a part of. We help each other. I once had a problem and they helped me through a difficult time. They regularly came to visit my mother and they also helped me fetching water and firewood. This photo shows us that we should love and visit each other because if we respect one another we can assist one another. If we have problems, my fellow children can help me. This picture shows that while some have plenty of things, a friend may have less and we can always join hands and do small fundraising to help someone through a difficult situation.” Millicent, 15 (Mbili/photovoice, see Picture 28)



Picture 28: Photovoice picture by Millicent, age 15

Friends are often an important source of support for many children. My data suggest that friendship bonds can provide psychological support and security, by giving them confidence in having someone to lean on emotionally during times of hardship. Friends were not only reported to provide emotional support, but also sometimes joined the young carers in doing home chores such as cleaning, cooking and subsistence farming.

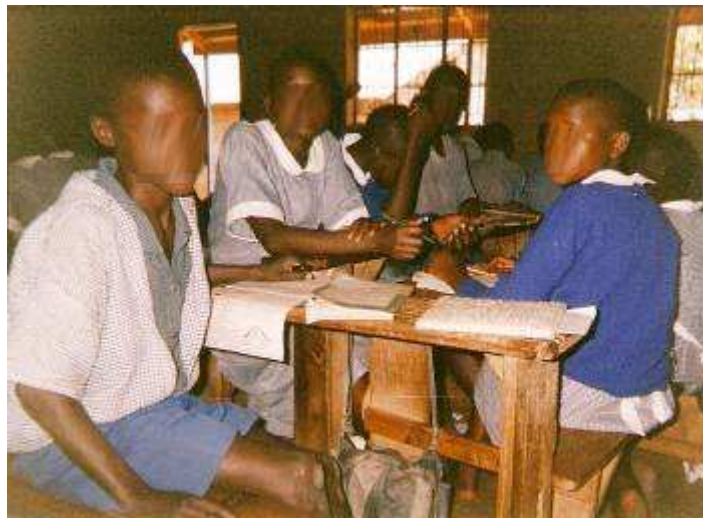
“The children on this photo are my friends and they also help me when my mother is sick. They assist me with washing clothes, cooking, cleaning and fetching of water.” Paddy, 15 (Moja/photovoice, see Picture 29)



Picture 29: Photovoice picture by Paddy, age 15

The strong notion of unity and togetherness (deriving from Harambee) evident in both communities was often articulated as a route to success and survival. It was used as a means of coping through difficult circumstances and tasks. Particularly children from Mbili acknowledged the importance of unity and team work.

“This photo shows us the benefit of working as a team. Team work helps. Being in a group has helped women in a village where they were weeding as a group, harvesting and this ensure that their crops did well and they got a good harvest.” Kevin, 12 (Mbili/photovoice, see Picture 30)



Picture 30: Photovoice picture by Kevin, age 12

In this section I have shown that young carers actively draw on and cope with difficult circumstances through resources available within their communities. These resources include their neighbours, community members (often within informal networks and community groups) and friends, and often require careful negotiation and navigation. This negotiation can take different forms, ranging from just asking for support (made easier through Harambee which promote solidarity and connectedness) to engage in reciprocal relationships (e.g. with friends, neighbours or foster parents) and be active recipients of support (knowing what to do and say in order to gain support). The strong sense of social cohesion found in both communities stems from Harambee, a value system that is entrenched in how many Kenyans live, it even appears prominently on the Coat of Arms of Kenya. However, as exemplified in the previous chapter, social resources are not available to every child and are constrained in particular by poverty and stigma. Although the previous chapter illustrated some of the limitations of the traditional support network system, indicating that the community plays a lesser role in providing care and support, this section has shown that community and social cohesion continue to play an important factor for children to cope with adversity.

5.3 Kinship ties

The third source of support outlined in Table 17 is the extended and immediate family. From the extended family, males were more often found to contribute monetarily, whilst female family members more often visited the household and supported them with food and nursing care. The children who did benefit from their extended family network reported little negotiation with their extended family members in order to access support, reflecting a perceived obligation to help their own kin in times of need. Fifteen-year-old Michael for example explains how his aunt and uncle assist when required.

“Like me when I’m taking care of my mother, there is an aunt of mine who normally comes and assists me in caring for her. There is also an uncle of mine who normally comes once and gives us money to buy for her what she wants.” Michael, 15 (Mbili/interview)

Caregiving was often a shared responsibility between immediate family members, with siblings often assisting with day-to-day activities (such as cooking, fetching of water and firewood). Forty-two of the participating children had siblings, with an average of 3.9. While some of these siblings are young and require care, many of the participating children had siblings, either older or only slightly younger, who assist with the caregiving.

“The photo shows my sister fixing the wick of the lantern. I took this photo because she is important to me. She assists me in washing and in fetching firewood.” Lucy, 12 (Mbili/photovoice, see Picture 31)



Picture 31: Photovoice picture by Lucy, age 12

It is often the oldest child living at home who takes the role of head of household responsibilities and is supported by younger siblings who do lighter duties. Having said this, 12 of the participating children did not live with their siblings, further highlighting the prevalence of children being sent away to care for extended family members such as aunts, uncles and grandparents. Children sent away to care may therefore be a particularly vulnerable group of young carers as they are removed from both their familiar surroundings, including school and friends, and have limited social support.

Although some responsibilities are typical for boys or girls, in times of need, gender appears to play a less important role. One adult said that a first born child “does all the duties, he/she is not viewed as either a boy or a girl, but can do any duty.” However, once the first born sibling moves away from home, the second born sibling typically takes over the caring responsibilities, but with continued support from the older sibling.

“My brother was the one helping us, he could send for us money to help us with food and drugs for our mother, we also used the money for our daily food.” Everline, 14 (Mbili/interview)

As with extended family members, older female siblings would often come back home and support their younger siblings in taking care of their ailing parent.

“I was taking care of my mother; feeding her and so on. During her last days when she was seriously ill, I was joined by my sister, we were together with her until her death.” Jael, 14 (Moja/interview)

Although ailing parents contribute increasingly less as their disease progresses, they can play some role in maintaining the household, at least for periods. In rare occasions, they may even help their own caregiving children in providing care for other family members, indicating the joint effort involved with caregiving.

“This photo shows my father, he is also sick and is unable to do certain things but he still takes care of me. He can burn charcoal to get money and I can use some of them on our grandmother.” Syprose, 14 (Mbili/photovoice, see Picture 32)



Picture 32: Photovoice picture by Syprose, age 14

Dependent on relapses and the disease stage of the infected, most of the participating children have at some point lived with an ailing guardian who is so sick that they cannot provide any support to the household. If the other parent is still alive, he or she often provides care and support for the ailing parent in a joint effort with their children. However, whilst most immediate and extended

family do support the children and their ailing parents, the stigma associated with HIV/AIDS may sometimes impede this support. Fourteen-year-old Pascal, for example, was the sole care provider of his father, as stigma led his mother and brothers to run away.

“When my father was sick, my brothers together with my mother ran away leaving me behind with my sick father. I was the one caring for him, supporting him to stand, washing him, giving him drugs.” Pascal, 14 (Moja/interview)

Because of the stigmatisation of AIDS, 14-year-old Pascal not only misses out on valuable support from his mother in a joint endeavour to provide nursing care for his father, but also loses out on some potentially important extended family support. Although Chapter four alluded to the importance of local understandings of childhood as a time of duty and service, there are limitations to this and the excessive caring duties imposed on some children, such as Pascal, who due to their lack of support are perceived to suffer.

It is the child that provides care, but it is the relatives who bring them the food and money required in the provision of care. If there is no such relative to support them, they will suffer because there is no other alternative for the child to access food as the child and the ill adult cannot get food to support themselves.” Male adult1 (Moja/interview)

Aside from placing the extended family as the most important support mechanism available to children in such circumstances, the above statement contradicts what really happens (see the forthcoming section), with most children investing significant time and energy on food and income generation.

This section has shown that siblings, parents and extended family members all play a crucial role in helping each other in the care and support of the sick or old, as well as each other. As many of the participating children are primary caregivers, they constantly have to negotiate and navigate through the resources available from their family network, ensuring they get the most out of them. This includes the sharing and distribution of responsibilities within the household and contacting older siblings or extended family members to come back or send money in emergencies. Unfortunately, not all children were successful in doing so (like Pascal), because of the impact of the stigma associated with HIV/AIDS and the high poverty levels that characterise Bondo district. Contradicting claims reported in the previous section that children are unable to meet their basic needs without adult input; the next section explores activities some of the children engage in to generate food and income for survival and in times of limited social support.

5.4 Active engagement through income generating activities

Aside from providing nursing care to ailing or ageing household members, the lack of productive and working adults means that some children in this study have the added responsibility of earning money and growing food in order to keep themselves and other household members fed and in

school. Whilst responsibilities differ according to the circumstances present in each household, all the children in this study were found to contribute significantly to wider household subsistence efforts. But as the previous section alluded to, these efforts were not always done single-handedly, but in a collective effort. To cope with the lack of resources and food, boys and girls engage in a variety of income generating and farming activities, some of which require children to negotiate access to land, animals and competitive market prices within their social environment. Furthermore, as outlined in Chapter four, local understandings of childhood as a time of duty and service, materialised through their socialisation and active participation in productive and reproductive activities in the household, allow the children to engage in income generating activities and be perceived (for most of the time) as active agents as opposed to passive recipients of support.

Most children reported on the importance of animals in generating food and income for various expenses. One of those expenses is school related costs. Thirteen-year-old Samuel, for example, took a photo of a cow that helps sustain his household: "I took this photo of a cow to show the benefits we get from it, like school fees, uniforms and money." Through the selling of milk Samuel has been able to cover some of his needs. Yet, many young carers not only have their own needs in mind, but also those of their guardians. Animals were seen to help them diversify the diet within the household, and enabled them to purchase medicines and nutritious foods for their ailing guardians.

"If I am caring for a sick person and do not have money, I can sell a cow or the milk to get money to help with the treatment of the sick." Edith, 17 (Moja/photovoice, see Picture 33)



Picture 33: Photovoice picture by Edith, age 17

"This photo is telling us that keeping chickens is a good idea, because poultry can help us through difficult times. When we have chickens, we can sell them and the money from that

can solve some of the problems, which we have. This photo is helping me in my life as I can help those who are sick with food. Sick people require a diverse diet and cannot only eat vegetables and these chickens lay nutritious eggs.” Millicent, 15 (Mbili/photovoice, see Picture 34)



Picture 34: Photovoice picture by Millicent, age 15

Cows, goats and chickens not only serve as important lifelines in sustaining the daily living of most of the children, but also give some of them hope for a brighter future when their animals reproduce and also serve as an insurance and asset. The children fortunate to have livestock or fertile fruit trees relied on them as insurance during times of hardship which gave them some peace of mind.

“I love our goats and that is why I took the picture. These goats of mine are important to me, they can help us when we don’t have money, and we sell them to get money for other things which can improve our lives.” Susan, 13 (Moja/photovoice, see Picture 35)



Picture 35: Photovoice picture by Susan, age 13

As this study took place in a rural area, the 'shamba' (garden, piece of land used for farming) played an important role for all the children taking part in this study. All the children had access to a piece of land that could be cultivated. Sometimes this piece of land, or the land surrounding their huts, had mature fruit trees that provided the children with important seasonal incomes.

"I would like to talk about this photo showing a mango and papaya tree as they have helped me in various ways. When I planted them, I knew that they would help me in the future during any difficulties and emergencies. I can pick them, take them to the market then I get money for paraffin which we use in our house at night. Even though they don't give me enough money for other things, at times the money contributes towards shoes for school, a bag and uniform. My grandmother also benefits from the sale of the fruit, but not enough to cater for all our needs. This photo tells me that many of the needs I have are met by the fruit which I grow myself and I know they can continue to help me with my small needs, but not with bigger needs. My work has helped me a lot." Janet, 15 (Mbili/photovoice, see Picture 36)



Picture 36: Photovoice picture by Janet, age 15

Janet proudly describes how she and her grandmother have benefitted from the trees that she herself planted long time ago, believing that these trees would help her in the future. The shamba also enables many children to grow vegetables and thereby generate money through the selling of these in the nearby market centre. Nearly all the children made reference to the importance of fruit trees and vegetables in generating income, often with reference to how it helps them purchasing school equipment (as Janet), and drugs to their ailing guardians.

"When my father was sick I had a vegetable garden which I used to cultivate and sell produce from to get money to buy drugs and food for my father." Pascal, 16 (Mbili/interview)

In working their shamba, the children had to decide what to grow based on a number of factors. Soil quality, experience, market prices and nutritional values are only some of the factors that the children reported taking into consideration in deciding what to grow. Some children knew that ground nuts have high nutritional value and are one of the best natural and locally grown foods that can be given to someone malnourished from HIV/AIDS and therefore showed considerable enthusiasm for growing this nut.

“I want to talk about this picture of groundnuts because they help me to get money and they help me with my diet. The groundnuts ensure I get carbohydrates in my body and make my life healthy. They are expensive in our area, so if I grow it, we can get a lot of money from it.” Debora, 15 (Moja/photovoice, see Picture 37)



Picture 37: Photovoice picture by Debora, age 15

The activities that Pascal and Debora and the many other young carers engage in, testify to their competence in participating, acting and planning according to their circumstances. Often from a very young age, young carers have life sustaining responsibilities and are required to make decisions regarding what to grow in their gardens to optimise productivity, when the produce is ready to be sold and at what price. Although gender only played a small role in duties carried out at home, supplementary income generating activities carried out in a more public space were highly gendered. Boys for example frequently engaged in the burning of charcoal. To make charcoal, the boys cut up timber and burn it in a controlled way so that the burned timber (now charcoal) can be easily lit and used for cooking stoves. Charcoal burning is an activity locally accepted to be damaging to the worker's health, because of the smoke they inhale during the process. The boys take the charcoal to the nearest market centre for selling. Although many boys take great pride in their charcoal burning, others see it as difficult and damaging.

“When I first started I was having problems as I had never burnt charcoal before and I had never fetched firewood for sale and it forced me to do so since it was my only source of income. I was not feeling good about it, it is a difficult job.” Francis, 14 (interview/Mbili)

Girls on the other hand offered more domestic services, typically to more affluent community members, such as doing laundry and working in their garden for small fees. A few girls also provided sewing services during the weekends to earn some extra money.

“During the weekend when I am not in school, someone whose clothes are torn can bring them to me and I can sew it for them and get some money.” Edith, 17 (Moja/photovoice, see Picture 38)



Picture 38: Photovoice picture by Edith, age 17

Younger children, regardless of gender, typically fetched firewood and took it to the nearest market place for selling, contributing significantly to the daily income of a household. One adult spoke of this potential.

“The child can fetch firewood, take to the market and sell, a child may carry three bundles tied together on the head; each bundle go for Ksh10 (£0.075). The child leaves for the market early to sell, go out and get more and eventually earn Ksh50 (£0.36). Others burn charcoal since this area is known for its charcoal burning.” Make adult9 (Mbili/interview)

Firewood is not the only thing that can be foraged and sold. A few children spoke of the value of leaves (black night shades). The leaves can be boiled and eaten with Ugali (cooked maize flour), which is their staple food. By taking a photo and describing it in detail, 15-year-old Janet tells us how poor she is and articulates how she and her aunt manage to find food in desperate times.

“I took this photo because we had no maize flour that day and my mother (aunt) had nothing to cook for us and we picked these leaves, cooked them and ate them without Ugali. The following day we picked some more leaves, took them to the market, sold them and managed to get a bit of money, purchased some maize and grounded it to flour so we

could eat it. From this I made porridge to my younger brother and sister and they drank and slept well that night.” Janet, 15, speaking proudly (Mbili/photovoice, see Picture 26 on page 175)

In taking this photo and deciding to describe to us in detail how she generates food and the benefits of her actions to her siblings, may indicate a sense of pride of achievements. Not everyone is able take such a positive stance on their situation. Some commented that these activities, combined with caring responsibilities, took up too much time and had a negative impact on their education.

“Caring and work can spoil your future completely, you can leave school entirely, which can ruin your future.” Pascal, 14 (Moja/interview)

The next chapter explores the meanings young carers attach to their circumstances in greater detail. As this section has alluded, all the children participating in this study engage in some form of income generation, ranging from animal keeping to subsistence farming and charcoal burning, illustrating their competencies, agency and decision making skills. The kind of activities the children engage in and the time spent on them differed according to their availability of social resources. Not all the children had land available for farming, or neighbours from whom they could negotiate a piece of land from. Similarly, some children were living in households with plenty of animals and others only had a few chicken. What this section has developed further is the idea that children’s active participation does not happen within a vacuum, but is dependent on the resources they are given or can negotiate access to via their guardians, neighbours and other community members (e.g. animals and land). However, the activities presented in this section rest on one particular social psychological resource, which is the acceptance of children’s work and an appreciation of their competencies and capabilities. If the children were not perceived to be capable of taking care of animals or grow vegetables, the children may not have been to negotiate access to those resources easily. Whilst many children were supported in this activities from other family members, some young carers were the sole income earners of their household and were under increasing pressure to juggle work, care and school.

Conclusion

This chapter has illustrated different ways in which young carers exercise agency as they negotiate with their local surroundings in coping with the daily demands of their lives. Based on the findings discussed in this chapter and illustrated in Table 17, Figure 12 has summarised the variety of social resources and types of participation that facilitate the coping of young carers living in difficult circumstances. These processes and coping strategies are important for service providers to take heed of as they develop interventions that promote the psychosocial well-being of young carers.

Various community structures such as churches, schools and teachers proved their potential to strengthen and support the coping strategies of young carers. Also neighbours, community groups and friends were reported to be important sources of support. At a household and familial level, the dynamics, the socio-economic status of the household, available family members and relatives all

had an impact on the resources available within a household. Poverty, stigma and climatic conditions posed some of the most serious limitations to social support at this level.

Although the resources discussed in this chapter are categorised according to their ecological levels of analysis, it is the interchange between the levels of analysis that allows for a comprehensive understanding of how children negotiate and navigate through the social resources available to them. Negotiations can be both explicit and implicit. Explicit negotiation included the children projecting their vulnerabilities and nurturing relationships with more affluent community members. Alongside more explicit strategies, was a more implicit strategy of simply asking for help. The negotiation of support was frequently based on reciprocity. Children helping their neighbours, knew they could count on them in times of hardship, and children setting up informal friendship support clubs knew that helping a friend now will benefit them in times of need. It must be acknowledged that many of the social resources described in this chapter only highlight their potential. It cannot be guaranteed that communities with similar structures and resources will be supportive. The children's ability to negotiate and navigate through these social resources partly reflects their inter-personal skills and other personal characteristics. Whilst individual-level factors do play some role in how the children cope, this chapter has shown that this is not the whole picture and that social relations and resources available at a community have the potential to facilitate (and can therefore also impede) children's coping.

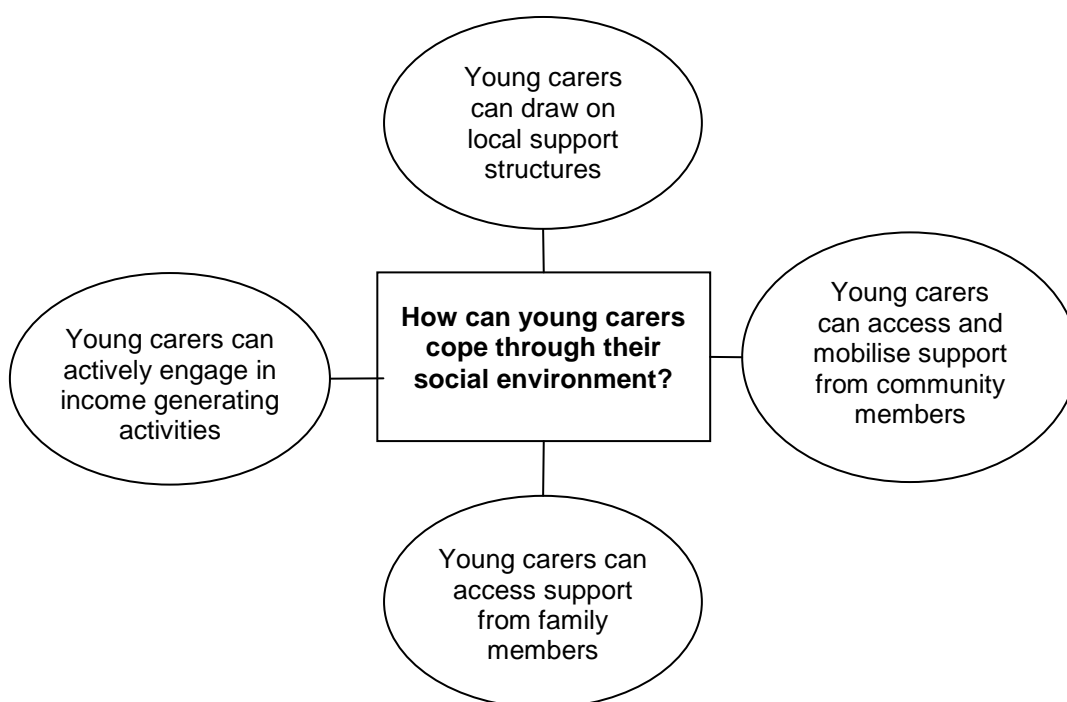


Figure 12: Summary of the social coping strategies of young carers

Although children's engagement in all these activities facilitates their physical survival, it does not prevent young carers from feeling depressed and sad, or being vulnerable to sexual abuse by relatives or other people taking advantage of their disenfranchised circumstances. Although many young carers have more power and control than their peers, it does not automatically grant them

the sense of empowerment and feeling of self-efficacy that will protect their psychological well-being. This chapter has briefly highlighted the importance of meanings ascribed by young carers to their circumstances. As the next chapter will outline, these meanings contribute to the psychosocial well-being young carers.

Chapter 6 - Psychological coping strategies

Introduction and chapter overview

Up until now I have discussed the contexts and circumstances that characterise the lives of many young carers, and the ways in which they navigate and negotiate support from their social environment through active participation. In Chapter four I explored some of the socio-cultural norms and local understandings of childhood that prevail in this context, which was followed by an account of some of the stressors that young carers and their communities are facing. In Chapter five I moved on to explore how the children successfully coped (or not) with these very difficult circumstances. I looked specifically at the social resources, symbolic or physical, that were accessible to many of the children. It is precisely the life experiences and social resources, as outlined in Chapter four and five that form the foundation for how the children understand their circumstances and make sense of them. It is against this background that this chapter seeks to explore the sense making processes of children themselves and the varied meanings that they attach to their circumstances, and how these facilitate or hinder coping.

Early on in the data analysis it became clear that young carers experienced a mix of emotions and had different attitudes towards caregiving. The majority of children, dependent on context and time, were able to recognise both the positive and negative sides of young caregiving and only a minority referred to their caregiving experiences as solely positive or negative. This movement of meaning between positive and negative attitudes becomes all the more evident when different research methods are applied. Appendix 18 exemplifies how meaning and sense articulated by one respondent was dependent on context and time. This complexity is of particular interest to this study as meanings (which can have emotional significance and thus be articulated as an emotion) form the basis of psychological coping strategies (Antonovsky, 1987; Brewin & Power, 1997). Furthermore, according to Tugade and Fredrickson (2004) positive meanings (and emotions) can sometimes (not always) correct or undo the negative effects of difficult circumstances, building psychological resilience toward improved emotional well-being. Whilst prescribing negative and/or positive meanings to a situation can in fact just be a neutral process of evaluating circumstances, this movement between positive and negative emotions and meanings help broaden people's momentary thought-action repertoires (Fredrickson, 2001), which may help widen the creativity and ability of young carers to negotiate social support.

In this chapter I will first explore the many positive meanings that the children attached to their circumstances, supporting my reservations about the overly victimological representations of orphaned and caregiving children presented in my literature review. I will then explore the negative meanings that some children gave to their situations and discuss some of the factors that might have given rise to negative meanings. I will then present findings related to how the children

actively managed these positive and negative emotions and meanings to construct a positive identity and finally explore how their ability to make overall positive sense (by drawing both on negative and positive emotions and attitudes) of these very difficult circumstances provides them with hope for the future.

As sense-making and the construction of a positive identity involves a process dependent on various factors and circumstances, the findings presented in the first three sections of this chapter will each be complimented with a case study, in which the life narratives of selected children are presented to illustrate the complex interplay of various factors impacting their psychological coping strategies.

As with the previous chapters, I am presenting the thematic network (step 3 of thematic network analysis) that forms the foundation for this chapter (see Table 18). The table illustrates the codes, issues and themes that emerged from the data corpus, giving rise to this chapter on the psychological coping strategies of young carers. This chapter will describe and explore (step 4 of thematic network analysis) the issues that emerged from the data, illustrated by quotes (related to the codes) representing diverse views and structured by the organising themes.

Table 18: Global theme: Psychological coping strategies of young carers

Organising themes	Basic themes identified	Issues discussed	Codes
Finding positive meanings to caregiving (discussed in Section 6.1)	48. The children's duties are socially recognised and encourage them to care.	<ul style="list-style-type: none"> • Appreciation by the cared for • Children receive thanks • Reciprocity of care 	- Strategic caregiving (20 children)
	49. The experiences they gain from their responsibilities are valuable.	<ul style="list-style-type: none"> • Recommend others to care • Future value • Independence 	- Recommending to care (3 children) - Value (14 children)
	50. Some children see caregiving as a personal growth experience.	<ul style="list-style-type: none"> • Gain coping skills • Independence • Stronger 	- Caring beneficial (5 children) - Caring makes me strong (3 children) - Personal growth (5 children)
	51. Some children are able to focus on the successes and positives of caregiving and thus find enjoyment.	<ul style="list-style-type: none"> • Self-satisfaction • Bright future • Pride • Caring makes them happy • They enjoy lighter duties 	- Caring is good (26 children) - Enjoyable duties (7 children)
Ascribing negative meanings to caregiving (discussed in Section 6.2)	52. Some children see themselves as a victims of external forces.	<ul style="list-style-type: none"> • Left alone with no support • Unpredictable disease 	- Punishment (5 children) - Victims (13 children)
	53. The impact of caregiving on education causes loss and damage to their future.	<ul style="list-style-type: none"> • Necessary for a prosperous future but compromised by caregiving • Lost time in school 	- Importance of education (11 children, 5 adults) - Loss or damage (14 children, 1 adult)
Constructing positive identities (discussed in Section 6.3)	54. Acknowledgement of caring roles help young carers construct a positive identity.	<ul style="list-style-type: none"> • Loved by the community • Exceeding local expectations • Other 	- Acknowledgement of caring roles (7 children, 1 adult) - Loved by the community (5 children)
	55. Many young carers see themselves as 'helpers'.	<ul style="list-style-type: none"> • Children an asset • 'Helping heart' • Prevent suffering • Loved by their community 	- Helpers (19 children, 1 adult) - Happiness (5 children)
	56. Young carers see themselves as being different from other children.	<ul style="list-style-type: none"> • Migration; new to village • Happily work • Disciplined • 'Helping heart' 	- Being 'other' (10 children)
Hope and aspirations (discussed in Section 6.4)	57. Children hope their active participation in the community will benefit them in the future. Either through reciprocal support or from the skills they have gained.	<ul style="list-style-type: none"> • Occupational dreams • Educational prospects • Wish to help others • Hope for the future • God and religion 	- Dreams and Aspirations (21 children) - Hope (6 children, 1 adult)

6.1 Finding positive meanings to caregiving

As the previous chapters have highlighted, caregiving *is* a challenge and the circumstances that lead to young caregiving are a source of stress. Despite these stressors, a surprisingly large number of children, as highlighted by Table 18, manage to find positive meanings and emotions that help them make sense of their difficult circumstances, as they acknowledge and articulate the benefits of young caregiving. These positive meanings and emotions have the potential to buffer and counteract the stressors they experience and build personal resources.

In this section I seek to explore some of the more prevalent positive meanings that were articulated by the children. These meanings entail both the positive recognition of their duties and

responsibilities by significant others in their social milieus, as well as positive emotions such as feelings related to their personal growth, pleasure, enjoyment and pride.

6.1.1 Social recognition and strategic caregiving

As theme 48 of Table 18 outlines, the recognition the children get from other members of their communities, echoing local understandings of childhood and caregiving, highlight what children experience as the positive social value of young caregiving. This suggests that caregiving has an intrinsic social value in this context, which young carers are able to strategically draw on to secure attention and support from others. Thirteen-year-old Samuel for example, as a result of his caregiving responsibilities, feels loved and valued by his community.

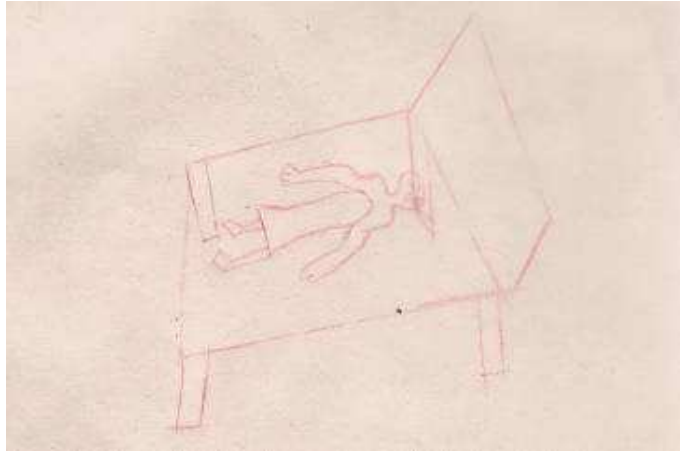
“All that I have done makes me happy. This is because I don’t do bad things in the community, and the villagers love me seriously for that and the fact that I like helping sick people.” Samuel, 13 (Moja/interview)

Everline also benefits from the attention and acknowledgement the community gives her through the recognition of her commitment and role in providing care. Everline has also learnt that in providing care, her support might be reciprocated by working and able family members, making caregiving a reciprocal strategy for negotiating support.

“I have learnt that it is good to take care of the sick, it provides one with knowledge on how to handle people. The community members are also proud of me, they love me, and I am proud of myself too. Also, the sick you are caring for might have a son who is working and she can tell this son to help you since you are the one assisting her.” Everline, 14 (Mbili/interview)

Thirteen-year-old Geoffrey also frames care as a reciprocal strategy, saying that he gladly provides care and support to a community member who has been friendly and generous to him in the past.

“I drew this picture because I wanted to talk about this mother. She is a mother staying in our home area and one day I was going to her place and found her terribly sick. I found her alone, her plates were dirty and she was very sick. I took my time to wash her dishes and cleaned the house thoroughly. This drawing is telling us that if you go and visit someone who is sick, you should help them. It is necessary to give good assistance if you are around sick people. It is not good to ignore such needy people. I really liked the mother because even though she was sick, she always told me stories and taught me various things. If she made food, she was always willing to eat with me and I think that a person with such love should not be suffering like this when sick. We should never leave them alone without assisting them.” Geoffrey, 13 (Mbili/draw-and-write, see Picture 39)



Picture 39: Draw-and-write picture by Geoffrey, age 13

Like Geoffrey, many children do not speak of caregiving responsibilities being forced on them, but voluntarily agree to commit to caregiving. They get on with the job with a rational insight as to why they are providing care, and as with Carren, often with a recognition of the social value community members ascribe to their efforts.

“After I returned home from caring for my grandmother, I carried on the same way, visiting orphans and the old. I fetch water, firewood and other things. I also burn charcoal [see footnote 6, page 110] with my mother and then carry it to the market to sell, earning us money. When my mother started feeling unwell it was my responsibility to work hard and feed my younger siblings and keep them clean. I carry on that way today and feel it is very good. People from the village are very proud of me.” Carren, 17 (Mbili/essay)

Another positive value ascribed by many children to their caring roles relates to the positive impact they believe these experiences will have on their future. Twelve-year-old Joyce for example believes that the caring experiences she has had will be of benefit to her in the future, and have made her a stronger individual.

“I feel happy because my caring experience will help me in future. **In which way?** If I am left alone, I will be able sustain myself as a result of these experiences. **What difference does it make to you that you do these things?** I become strong; I don't become a weak child.” Joyce, 12, (Mbili/interview)

The statements by Joyce also indicate confidence in her ability to cope and survive through difficult circumstances. However, caring is not only seen to help the children in the future, but also regarded as having an immediate value, which was often articulated through the independence children gained from realising their potential capabilities to sustain livelihoods.

“My responsibilities have helped me because at this moment, I am able to do many things that will earn me money. I can buy my own things and depend on neither my mother nor grandmother. Now I can even buy my own clothes.” Jane, 17 (Mbili/interview)

Aside from the independence reported by both Jane and Joyce, twelve-year-old Mercy speaks of how her experience of providing care for one of her grandmothers prepared her to take care of her sick mother. She therefore speaks of caregiving as a transferable skill, rather than a duty, which requires heart and love, actively encouraging other children to provide care.

“I once cared for this grandmother who was a co-wife to my real grandmother; she died after a short illness. She is one of the people I have helped. I think it is good to help old and sick people and it needs heart and love. Now I’m confident in assisting people, even my mother who is now sick, I can’t fail to care for her. I think and wish that children should care for such people.” Mercy, 12 (Mbili/essay)

Nevertheless, not all children were able to identify this positively the values that characterise young caregiving. Although 14-year-old Pascal from Moja community also sees caregiving as a learning curve, the sense he makes of his experience is more mixed. Whilst he acknowledges the moral value of caring, he still does not see much good coming out of his experiences.

“Caregiving has enabled me to know how I can attend to her needs, since I have done it before. I can do it a little bit better this time and with some courage. What are the good things about children who provide care for adults? There is nothing good about it at all, but they may get blessed.” Pascal, 19 (Moja/interview)

The values and deeper meanings highlighted in this subsection point to the way in which symbolic social resources, such as local understandings of childhood and caregiving, facilitate the positive recognition of the duties and responsibilities of young carers, both by themselves and by other community members. The next subsection will move away from social and symbolic resources to examine children’s personal experiences and emotions associated with caring.

6.1.2 Positive evaluations, meanings and emotions

Positive meanings and emotions serve as markers of a flourishing and optimal well-being (Fredrickson, 2000, 2001). As my coding framework in Table 18 depicts, many children ascribed a sense of personal growth, happiness, satisfaction, value, enjoyment and pride to young caregiving, each of which will be explored in this subsection.

Many children commented that the very activity of caring served to distinguish and distance them from non-carer children, who they depicted as lacking caregiving children’s work ethic and willingness to take on menial but significant responsibilities. They therefore saw young caregiving as an opportunity for personal growth and development, something which makes them better people. This is exemplified well by 17-year-old Katherine who says:

“My life differs from that of other children in the community; I am saved, both in actions and deeds. I work differently, I don’t mind carrying firewood bundles on my head to the market

to sell and I enjoy doing it. Others don't want to carry; they feel ashamed to do this."
Katherine, 17 (Mbili/interview)

Also Syprose, a 14-year-old girl from Mbili community speaks of caregiving as a positive growth experience that has provided her with the necessary skills and attitude to get on with the hurdles and demands of life.

"Caregiving has changed my life to cope with difficult situations. It has made me aware of how I should handle the sick and taught me to be active and positive in doing work."
Syprose, 14 (Mbili/interview)

A large number of children, when asked what makes them happy, referred to their duties and responsibilities. The sense of achievement and control gained from growing vegetables successfully for example, was a source of happiness and satisfaction to many children.

"I enjoy weeding my vegetables; I become happy when I see them grow well and healthy. This makes me happy." Zeddy, 16 (Moja/interview)

The pleasure and enjoyment Zeddy and many other children gain from these seemingly small daily achievements, must be understood in light of their importance. For Zeddy, it could potentially be life threatening if his vegetables did not grow well and he had a failed harvest. For other children, pleasure and enjoyment came from duties that are made easier, such as access to a bicycle when fetching water, or if the nearby water hole is full of water. This is also the case for 14-year-old Pascal, who finds pleasure in looking after cattle, an activity often perceived as relaxing as the children can rest on the green grass.

"What makes you happy? I can fetch water using a bicycle. That makes me happy.
Anything else? Looking after cattle and tying them to a green field. That also makes me happy." Pascal, 14 (Moja/interview)

Many of the positive meanings and emotions described so far highlight a sense of pride and satisfaction of their achievements. Although their pride is only articulated implicitly, it was often emphasised through the photovoice exercise. Janet for example, in taking photos of the things that help her get by, not only decided what she wanted to share with me, but used her photos as an opportunity to explain how her actions have helped herself and community members cope with difficult times.

"The photo relates to me and other community members as it shows how people often get by from fruit trees. It shows that I get my own things from my own work and I don't have to go to people and ask for assistance. I used to go to school with a plastic bag and without a uniform and nobody cared. But selling fruits has helped me a lot [...] the photo reminds me of how we have passed through hard times, when there is no one to lean on; we defended ourselves for everything we needed." Janet, 15 (Mbili/photovoice, see Picture 36, page 183)

What the many statements presented above do not adequately show is the context against which the children construct positive meanings. To this end, a case study of Carolyn, a 15-year-old girl from Mbili community will now be presented, highlighting how Carolyn constructs her caregiving experiences as good and important, even within the context of difficult circumstances.

6.1.3 Case study: Carolyne, age 15

Carolyne's father died of an illness when she was 7 years old and she began taking care of her mother at the age of 10. For two years Carolyne provided nursing care and psychosocial support to her mother and kept the household running. She cooked and fed her, washed and massaged her body. In addition to the nursing care, "I also did the other house work such as cleaning the house, washing utensils and fetching water." The workload was heavy and interrupted with a change when her mother was admitted to the hospital. In the absence of adequate nursing care at the hospital, Carolyne continued to care for her mother in the hospital, forcing her to leave school. Carolyne's mother died in the hospital. Throughout this ordeal, Carolyne was largely left to cope on her own, taking head-of-house responsibilities. She received relatively little support from her extended family, possibly as a result of the stigma associated with AIDS. But as for many other young carers, her caregiving role did not end here.

Soon after the death of their mother, Carolyne and her little sister moved in with their grandmother who was very old and required care and support. All her adult children had died and she was dependent on her grandchildren. Despite taking on significant caring and household chores, Carolyne was determined to return to school. But soon after re-entering, her class teacher advised her to leave school as she was not attending classes consistently due to her responsibilities at home. In addition to her poor attendance, Carolyne suffered from slight visual impairment and had difficulties reading what was written on the blackboard. Determined to stay in school, Carolyne refused to drop out and continued with her education. Whilst dealing with her personal health issues and education, Carolyne also lost the practical support and friendship or companionship of her little sister. "My sister was sponsored (to go to school) by some whites and she is now in Nakuru." Aside from her sister, Carolyne does not mention receiving support in her provision of care from anyone else. This is also reflected by the amount of time she spends on caring. "You work throughout the day, no time for resting." However, she could occasionally negotiate her way to material or food support from community members. In describing a photo of a woman who has supported her, she says: "this photo reminds me of the kind of support and love we get from the community members. If I need anything, I tell them and if it is available, I will get it."

After two years of caring, Carolyne's grandmother passed away. She was left to stay with her grandfather who was mistreating her, often leaving her to spend nights outside where she describes her encounters with hyenas. Carolyne quickly moved in with her aunt who has been supporting her well since. "If I ask my aunt to buy me something she will not ignore me, even though I am not her

child. No, she will do for me the same as for her own children.” Carolyne and her aunt jointly provide care for her aunt’s elderly co-wife.

The numerous caring experiences Carolyne has been confronted with have facilitated a reflective caring identity, one that acknowledges both the negative and positive impact caregiving has had on her. Although she is now in foster care with her aunt (whom she calls mother), she continues to provide care and support for the sick and old in her community, now with help from her aunt. Although Carolyne says that “the lives of children caring for the sick is not good”, she describes her circumstances and work as something she ‘just had to do’, without complaints, and something which is important. Carolyne’s experience highlights both the difficulties she has faced in providing care, as well as the way she has dealt with them. Aside from the periodic support she has received from her sister and aunt, her social environment has been of limited support, yet she accepted her role as carer and simply ‘got on’ with the job.

To summarise Carolyne’s narrative and positive evaluation of difficult circumstance, I have extracted quotes from her transcripts and rearranged them in a chronological order in the form of a poem. Poetry has previously been used to re-present narratives of research participants (cf. Poindexter, 2002; Szto, Furman, & Langer, 2005). I believe re-presenting Carolyne’s accounts into a literary format, such as poetry, honours the message which comes from her stories and the power of her experiences, rendering the essence of her meaning construction⁸.

All that I have done has been important

I was first caring for my mother
when she was sick.

She was too sick to do anything.
I was the one to wash her and feed her.

It reached a point where I could not sleep.
She was crying of pain all the time.
She needed water and wanted to be massaged.

I also did the housework.
Cleaned the house, fetched water and prepared food.
I had to leave school.

After her death my grandmother fell sick.
I started caring for her.
We had no money, I could not take her to the hospital

I have had problems.
I have been committed to caring and had little rest.
But all that I have done has been important.

This section of the chapter has highlighted some of the many positive meanings and emotions articulated by young carers. It is evident that many of the positive meanings relate to local understandings of childhood as a time of duty and service, which in a context of AIDS, are being

⁸ The poems presented in this chapter are published in a paper on the psychosocial well-being of young carers in Kenya in *Globalisation and Health* 5:8 (August 23)

tailored into a social recognition of children's role in providing care and support to less able community members. These more positive meanings and emotions help children to see caring as a positive challenge and an opportunity for personal growth and socially valued service, rather than as a hindrance or obstacle in their lives. The case study of Carolyn shows that despite her many challenges and difficulties, she still manages to develop a meaningful life history that allows her to regard caregiving as an important and mostly positive experience, something that has shaped her into the caregiver she voluntarily continues to be. The above quotations begin to suggest that the ability of young carers to speak very positively about their caregiving experiences is an outcome of a complex interrelationship between the positive rationalisations and attribution styles the children have and the quality of their social support available to them, an assertion I will elaborate on in the forthcoming sections.

6.2 Ascribing negative meanings to caregiving

Although many children ascribed many positive meanings to caregiving, a number of them also ascribed more negative meanings to their caring experiences. Negative meanings have the potential to inspire a 'combat' or 'conquest' response as the children fight their circumstances (Lipowski, 1970). However, in the cases observed in this study, the negative meanings often reflected an anxiety and fear of the future or an anger and annoyance which seemed to point to little hope of positive resolution.

A few children spoke of their caregiving as a punishment, something which they do not deserve or should be doing, ultimately seeing themselves as victims. This is exemplified by 17-year-old Edith, who reflects back on her first caregiving experience which she had at the age of 12.

"I was really feeling bad about caregiving, since I should be in school and complete my studies, I was at home caring for my grandmother; at night I couldn't do the homework which was brought to me by my fellow students. My grandmother could cry at night in pain, wanting me to massage her. All in all it is not good for young children to care for the sick or the old. It is good for the daughters-in-law to do the caring, or other old people in the community, but it is not good for the children. I was really made to suffer." Edith, 14 (Moja/interview)

Varying meanings were ascribed to past experiences, with no overall pattern across the data set. Older children, when reflecting on their previous caring experiences, ascribed very different meanings to them, as seen in the quotes above. Whilst younger children were more likely to ascribe positive meanings than older children (possibly as a result of their different levels of critical consciousness), younger children were also sometimes found to ascribe negative meanings. Fourteen-year-old Francis for example sees his circumstances as an unjust punishment. He feels trapped and appears to be emotionally vulnerable.

"My mother is so annoying such that nobody can take care of her apart from me. Even though I have other brothers, they have given up in caring for her. I sometimes feel that I

should have not been born and for this reason, I curse the day I was born like I curse my duties.” Francis, 14 (Mbili/essay)

Francis’ mother is mentally ill and difficult for Francis to control. Her unsocial and violent behaviour makes it difficult for him to empathise, further complicated by the lack of help from his brothers, leaving him entirely on his own to sustain his and his mother’s livelihood. Whilst Francis’ situation represents an extreme case, a number of children refer to their caring duties as having caused them irreparable loss and damaged their well-being and development. In the interviews, this was usually reported with reference to their educational attainment. Edith also reports on her difficulties in getting back to a daily routine, with flash-backs, a sign of post traumatic stress, inhibiting her from concentrating in school. She reflects on these flash-backs and her experiences and their negative impact on her education.

“My grandmother was sick until she died [...] I then went back to my former school, but my head teacher refused to let me go to class four, leaving me to repeat class three. My father asked another school and the teachers agreed to interview me. I passed and joined class four. Although I was in school, I kept on thinking of what had happened to me in my life. At times I could think back, only to find myself crying in class. I could not study well; instead of studying I was thinking of my plight with the grandmother. The truth is that all of this was not my choice; the caring should have been done by my parents or someone who had completed his/her education since it interfered greatly with my studies. I feel bad while caring since I waste a lot of my time while doing duties for the sick/old which I could otherwise use on studying. I lost a lot while doing these; no exams are set as regards caring.” Edith, 17 (Moja/essay)

For Edith and many other children, particularly from Moja community, the impact of caregiving on education outweighed any social recognition and perceived social value of caregiving. As Edith mentions, there are ‘no exams on caregiving’ and as such it has little value to her. For many children in Moja, education was perceived as the only way out of poverty and caregiving was seen as an external force that would cause impeccable loss and damage to their future.

“Caring can spoil your future completely; you can leave school entirely, which will completely ruin your future life.” Pascal, 15 (Moja/interview)

It may be no surprise that some children see themselves as victims and sufferers. This was especially the case of children who had a limited social support network and those who had to cope with more extreme circumstances, such as caring for multiple adults at the same time.

“I drew this picture [see below] to remind me of the kind of help I have offered to my grandmother. Our grandmother has been sick for quite some time and it is me who has been helping her out. Then my mother got sick and I cared for both of them, so I have always been suffering.” Jael, 15 (Moja/draw-and-write, see Picture 40)



Picture 40: Draw-and-write picture by Jael, age 15

Having said this, a few of the older children, again upon reflection of their first caring experiences, reported that the suffering was only momentarily, highlighting that caregiving is something the children can get used to and accept with time.

“They [children providing care] are suffering because they are still young, children of that age are still playful and they can’t play if they are caring. For the first few months of their caregiving experience they may feel they are suffering, but thereafter they will just feel a little disturbed.” Jane, 17 (Mbili/interview)

Again, to put into context the circumstances that surround some young carers, I want to turn to the case study of 14-year-old Francis. Unlike Carlyne, Francis has not been able to turn his caregiving experiences into much positive. Whilst he acknowledges the social recognition that comes with young caregiving, and the fact that he is loved by the community as a result of his ‘good deeds’, his overall evaluation of his current situation is one of unhappiness.

6.2.1 Case study: Francis, age 14

Francis began providing care from a very young age. In the years running up to his seventh birthday, Francis was taking care of his father who suffered from AIDS. Francis did not receive much support from his mother, who because of stigma left the house, leaving 6-year-old Francis alone with his sick father. Francis’s older siblings lived away and only provided limited support, mostly in terms of food. Francis spoon fed his father and cleaned his body, also in the most intimate of places. When Francis tried to seek out help from his mother who was staying with her brothers, he was chased away by his uncles. When asked about how he coped with the situation, Francis

explained: "I had a vegetable garden which I used to cultivate and sell the produce from in order to buy drugs for my father or anything else he needed." At the age of seven, Francis's father died. Following his father's death, Francis moved in with one of his brothers and returned to school. To Francis's dismay, he was told by his teacher that he had to repeat class 2. Francis had a difficult year: "It was painful to see my classmates in class 3. I did not forget the caring of my father for the whole first term and I could only think about how my father died. This thinking left me at the bottom of my class. But in term 2 I started to forget these things slowly."

Francis's caring experiences did not end here. A couple of years later his brother also got ill, but this time Francis was not alone in caring, he was joined by his brother's wife. "Fortunately we were two of us, so one cared at night and another during the day. I especially cared during the night and it made me unable to concentrate as I almost slept in class." As his brother became bedridden, Francis left school once again and had to repeat class four when his brother died.

Following the death of his brother, Francis moved in with his grandmother where he currently stays. He supports his grandmother with those tasks she cannot perform due to old age and is reviving his relationship with his mother, who decided to return to the community two years after his father's death. In reflecting on the limited support he received during caregiving, which was a key contributor to the negative meanings he attached to his experiences, Francis laid heavy emphasis on the relative poverty that he endured. "Other children have their school fees paid for by their parents, they have good clothes, good shoes and they look nice whilst I cannot afford to look nice because of the little money I have." In comparing his life with other children, Francis clearly sees himself as a victim and the injustice surrounding his circumstances, yet despite these victimological representations, Francis has not lost hope. "I know and hope that my life will be good."

The following poem summarises Francis' experience and exemplifies the very difficult conditions in which Francis was providing care. It is evident from Francis narrative that he feels a tremendous sense of loss and damage to his current situation, circumstances that have pushed Francis to feel a sense of relief following the death of his father.

All this suffering

This drawing [see Picture 41] shows the kind of care I have given to the sick

My mother was nowhere to be found
My father's sickness got worse and worse
It forced me to leave school

He was unable to walk
I washed off his faeces
He disturbed me during the night
I was very sad; I was left alone with my father

When he died, I thanked God; he made me suffer a lot
One of my brothers fell sick; this also made me leave school
I had to repeat class four when my brother died
All this suffering made me go to my grandmother's place

I am now in class 7 and learning
I help my grandmother with harvesting,
fetching water and cooking
It shows good behaviour and the majority loves me.
I am still not happy with the kind of life I am living,
though I am in school



Picture 41: Draw-and-write by Francis, age 14

In this section I have discussed the role of disrupted or terminated education in contributing to many of the negative meanings ascribed by the children in this study. As most of the children articulating negative meanings are from Moja community, it might indicate that the local schools in Moja are less sympathetic to the children's caregiving responsibilities (compared to my earlier findings which suggested that schools in Mbili were supportive of child carers). It may also reflect the community's emphasis on the importance of education. Moreover, the children prescribing negative meanings also appeared to be comparatively worse off, both in respect to social support networks and in terms of (recurrent) duties and responsibilities. The two case studies presented thus far, despite being presented under contrasting (positive versus negative meanings) headings, illustrate well the movement and cognitive dissonance of meaning, which seems to be dependent on the context (e.g. in relation to education or in relation to the social recognition of caregiving). The next section

explores how, despite a mix of positive and negative meanings and emotions, some children still manage to construct a positive carer identity.

6.3 Constructing positive identities

The many positive and negative meanings ascribed above reflect the subjective and personal meanings that young carers ascribe to their experiences. These meanings are influenced by their individual circumstances, social support networks and social environment. Although many of the children draw on a mix of positive and negative meanings, dependent on context and time, nearly all the children in the study depict their role as caregivers in some positive light. As indicated earlier, local cultural understandings of duty and childhood (discussed in Section 4.1) appear to serve as useful symbolic resources in the construction of positive meanings (discussed in Section 6.1). These discussions have already alluded to the significance of these symbolic resources for constructing positive identities. This section will therefore look at how these symbolic resources are played out and translated into positive identities and the significance of that.

In stressing the process of becoming a young carer, many of children speak of themselves or other young carers as different, primarily as children who have undergone significant personal growth. To become a young carer, Debora for example talks about the challenges and sacrifices one has to accept to grow into a carer, a child with ‘a helping heart’. Debora’s statement is also a reminder of the hierarchical power relationship that exists between adults and children.

“What makes a sick person happy is when you help and provide care for the sick willingly with the whole heart despite being hassled by the sick that have so many needs. If the sick person realizes that you don’t wish to go where they send you, they will become angry. But if you go willingly, they will become happy and will appreciate it a lot and give you God’s blessings so that you grow with a helping heart.” Debora, 15 (Moja/interview)

Whilst this may outwardly sound like an oppressive relationship, Debora is able to rationalise her situation by looking at herself as a child with a helping heart, coping through a positive carer identity.

As I briefly allude to in Chapter four, the majority of children implicitly conceptualised themselves as ‘helpers’. This is also the case of 14-year-old Catherine who after caring for her parents now lives with her grandfather. Through a description of one of her photos, Catherine speaks of how she has continued with her commitment to provide care and support of vulnerable community members, supported by her grandfather, explicitly conceptualising herself as a ‘helper’.

“I took this photo because he is my grandfather. I took this photo because my grandfather gives me support and helps me care for the others. The picture connects me with the community because we are helpers.” Catherine, 14 (Moja/photovoice, see Picture 42)



Picture 42: Photovoice picture by Catherine, age 14

The idea of being a ‘helper’ (as with Catherine) often came from recurrent caring experiences, suggesting that you do not become (in an identity sense) a ‘young carer’ after just one short experience of providing care. Perhaps as a consequence of more long-term caregiver experiences, there is also a realisation by many children of the role their personal skills play in providing care. Children often referred to their caring experiences as a source of skills and independence which would stand them in good stead throughout their lives. Practical skills gained from caring included caring and nursing skills, income generation and a range of personal qualities such as empathy, commitment and hard working. In the process of developing a caring identity, some children saw these skills as a personal gift and talent, something which is lacking in non-caring children. Michael speaks of the process through which some young carers discover their ‘carer’ talent (or identity) and encourages them make good use of them. He also speaks of the difficulties (slow beginnings) that young carers may experience in the beginning, but is confident that a discovery of their skills and talents are of far greater importance.

“There are different ways to help the needy. You use your talent to help somebody. The greatest challenge is to identify the talent that God has given you. We can know this by choosing the leisure and interest we have in things. When we discover our talent we must put it into use to help people. We should not be discouraged by slow beginnings, as they will become good endings. Our talents are meant to serve God and others. When we help the needy we use our talent. Sometimes I help my mother by fetching water, firewood, wash the clothes and the utensils. I always find ways of helping the sick. When I help my parents I feel good and they also help me in time of trouble and with school. When one of my parents is sick, I help him or her by giving them food to help them recover from the disease they have. Helping somebody teaches us to love people and it promotes peace within the family and in the community.” Michael, 15 (Mbili/essay)

The statement provided by Michael is a good example of how the children internalise and develop a caregiving identity, framed not only on their circumstances, but according to their skills. Furthermore, Michael also speaks of how his talent, and how he uses his talent and positive care identity, can help him negotiate support from his social environment.

“When we use our talents to help others, we are giving a good service to others. This photo is related to my life in that when I use my talent to help others and use it wisely, God also feels happy. Sometimes I also get gifts from others when I help them. Some give me gifts like clothes and food when they can afford. Helping the needy has really improved my life.”
Michael, 15 (Mbili/photovoice, see Picture 43)



Picture 43: Photovoice picture by Michael, age 15

Whether a child sees him- or herself as a ‘helper’ or someone with a ‘talent’, the way in which children construct a positive caregiving identity is complex and differs from child to child. However, to exemplify the process through which a positive caring identity can be constructed and to highlight the power of such an identity in coping psychologically, a case study of 13-year-old Samuel will now be presented.

6.3.1 Case study: Samuel, age 13

Samuel was 9 years old when he first realised that his father was ill. He noticed his father’s swollen hands and joints and explained these in terms of a spell having been cast on his father by someone who was jealous of his job. Soon after “another spell was cast by another person on his legs”, and he was bedridden. Although he was taken for prayers, his condition never changed. He had sores all over the body and Samuel applied creams to his body, washed him, gave him drugs, prepared food and spoon fed him. Although his mother was around to help, she too got sick and was able to offer less and less support. Samuel’s father died in 2005 when Samuel was 11 years old and he currently cares for his mother. Samuel is not caring for his mother alone. His little sister helps out by fetching firewood and water and assists Samuel where ever she could. Samuel also has a supportive extended family network. His aunt has moved in to help them out. Aware of this support, Samuel’s assessment of his situation allows him to reflect on local understandings of childhood as a time of duty and service and his perceived identity and role as a young carer, and draw him to move in with his ageing neighbour who had been deserted by his family: “I went and lived with him, helping him out, cooked for him, fetched water, took care of the poultry and ensured he was clean.” Rather than concentrating on the care of his mother, Samuel’s decision to move in with his ageing

neighbour not only reflects his commitment to be a young carer but also his assessment of his circumstances as low risk.

Samuel has always played an important role in sustaining the households in which he has lived, drawing on the resources available to him through his parents. He cultivates land with sorghum, some of which he sells to buy basic amenities or chicken or goats. "Chickens help me in providing eggs, meat and give us money if we sell them [...] at times I sell a chicken to get school fees." Samuel's family also has a cow whose milk can pay for his school uniform and which can be slaughtered for a funeral. The resources available to Samuel, combined with his active participation, allow him to cope. From a social psychological perspective, the availability of social resources and support makes it easier for him to successfully exceed local expectations of childhood and from that create a positive caring identity. This positive identity came out strongly in his narratives as summarised in a poem below:

I have a helping heart

How are you different?

I like helping people.

I have a helping heart,

if I have something I share it

What makes you happy?

All that I have done makes me happy
the villagers love me seriously
as I don't do bad things in the community

How is life as a carer?

If I care for a sick person,
I'm happy since I get blessings from God
It is not good for one to suffer.
There are no negative effects

The poem indicates that both his religious faith and his mobilisation of local understandings of childhood, have enabled Samuel to create a positive caregiver identity, based on the acceptance, love and blessings he gets in return for his caring, both from the community and God.

Samuel therefore sees caregiving as a strategy through which he derives recognition and support from the community. In addition, Samuel distinguishes himself from other children, arguing that "if I have something I can share it with other children, I don't deny them", believing many other children "don't share what they have with others, they pretend not to have anything." Samuel values this quality highly and attributes this good quality to his caregiving experiences, reflecting a relief for having it.

The poem summarises and links the positive meanings that Samuel attaches to caregiving and the construction of a positive caregiving identity, an identity that influences Samuel's psychosocial well-being and coping.

This section has discussed and illustrated some of the ways in which children can construct positive caring identities. In seeing themselves as ‘helpers’ or someone with a ‘talent’ the children have undergone some personal growth. However, not all children are able to reflect upon this growth. Children who have only recently found themselves in a situation of providing care might not have had the opportunity to reflect upon their experiences, or had a need to do so in their effort to cope psychologically. It therefore appears that children with more long-term and recurrent caring experiences are more likely to report on caregiver identities. One exception will be children like Francis whose circumstances were so severe that he could only ascribe predominantly negative meanings to his situation. To highlight their heroic acceptance as caregivers, and further distance themselves as ‘other’, the children also spoke of the difficulties and challenges they have had to accept in reaching to a caregiver identity. Whilst many of the children are able to collectively agree on this social identity, this section has shown, and further exemplified through a case study of Samuel, that the development of a positive identity and its role in healthy psychological functioning is a result of a negotiation with the local context and local understandings and expectations of childhood. The next section explores how the meanings, emotions and identities presented so far can be translated into hope and an overall perception that goals can be met.

6.4 Hope and aspirations for the future

Section 4.3 outlined some of the many difficulties and challenges that young carers face. Nevertheless, as this final organising theme of Table 18 illustrates, a surprising number of children still managed to find hope and confidence in their future. This is a significant finding as how children think of their future and goals in life can make a difference in how they handle risks and difficult circumstances (Snyder et al., 1997). Hopeful thinking and aspirations for the future is therefore an important psychological strategy that can work as an antidote in difficult times. This section will outline the sources of hope that were identified from the children’s accounts.

A useful strategy to aid a sense of hope in difficult circumstances is to compare your own circumstances with that of others. A few young carers were able to put their circumstances into perspective in this way, as done by 17-year-old Carren.

“I know of a family where the younger sister is the main person who is ensuring they get food to eat, she fetches firewood to sell in the market, but that is still not enough for them, they starve. So when I see the kind of life she leads, I feel mine is better.” Carren, 17 (Mbili/interview)

Whilst this comparing might be the cause of grievances and negative meanings in one context (e.g. when comparing to non-caring children), the kind of comparing done by Carren, and many other children, can facilitate hope as they discover their circumstances are not as bad in comparison to other children. They are not at their wits end.

A less subtle source of hope is the ownership of animals. I mentioned in Chapter four that goats and animals can serve as a form of insurance, giving them something to fall back on in difficult times. This safety net, together with the possibility of the animals reproducing, gave many children a sense of hope. These more materialistic sources of hope are often complimented by more spiritual convictions, such as having faith in God, which play a central role in providing many children with hope. This is exemplified by 17-year-old Jane, who explains how she envisions the possibilities that come from goat ownership and with support from God.

“I want to talk about this picture [see below] because I hope they will help me and I hope that if God is willing, will benefit me. I really have great hope with these goats and God willing, if I am to go back to school, I can sell goats to get a uniform, a pair of shoes, socks and I can also help a child whose parents are sick, buy clothes for him or her.” Jane, 17 (Mbili/photovoice, see Picture 44)



Picture 44: Photovoice picture by Jane, age 17

Jane admirably not only thinks of how the goats can help her, but has an aspiration to help children in a similar situation to hers but who cannot benefit from goat ownership. Many children took photos of goats and other animals, signifying the importance of having access to such resources (e.g. goats) and their role in facilitating hopeful thinking and coping. Although God plays an important role in building hope for Jane, she is very much an active participant of her own destiny. However, as many of the children have experienced failure and very difficult circumstances, not all of them see themselves as having an active role in determining their destiny and future. Although 13-year-old Susan from Moja community has got hope to enter and pass secondary school education, she refers to this destiny as something which is in the hands of God, with little belief in her own capabilities.

“What I’m hoping for in future is that God can help me through Secondary and beyond. I’m also praying for a long life.” Susan, 13 (Moja/interview)

It is evident from the last two accounts that religion plays an important role in framing the meanings people give to their experiences and is an importance source of hope. Whilst many children refer to

God as a source of hope, some children found hope in their own capabilities. Encouragingly, despite having been abandoned by his brothers and mother after his father got sick, 14-year-old Pascal from Moja community still believes that his hard work in school will eventually pay off and has hope for a bright future.

“I still have hope that when I study hard, my future will look bright.” Pascal, 14
(Moja/interview)

With hope of a brighter future and a belief in their own competencies, many children spoke enthusiastically about their dreams and aspirations. Both Jane and Millicent from the Mbili community have been inspired by their experiences to work in a field that seeks to support children like her, reflecting her identity as a carer. Not falling short of aspirations, Millicent wishes to go all the way to University and become a doctor.

“I would like to be a doctor so I hope I will pass my K.C.P.E, K.C.S.E and University. I would like to help the sick as well as the old people. I would like to help orphaned children and widows so that they can get jobs and live well.” Millicent, 15 (Mbili/essay)

Other professions mentioned by children include police officer, district commissioner, teacher, nurse, singer and musician. What this section has highlighted is the different levels and sources of hope that many young carers have (and some do not). Drawing on faith, available resources (such as goats), their own confidence and passion, many young carers are able to translate their caring duties and hard work into hope for a brighter future. As hopeful thinking and future aspirations keep the resourcefulness of children in difficult circumstances active and on track, highlighting the sources of hope is significant for any programmes that seek to strengthen the psychological coping strategies of children.

Conclusion

In this chapter I have sought to illustrate some of the more prevalent psychological coping strategies reported by the children in this context. In doing so, I have built on earlier chapters that highlighted the relationship between the dynamics, change, context and content of being a child in an AIDS affected community (Chapter four) and the availability (or not) of particular types of social support (Chapter five) to their psychological coping. Only a few children reported entirely positive or negative meanings to their caregiving experiences, this chapter has highlighted the complexity of sense-making, suggesting that most children do attach a mix of positive and negative meanings. Negative meanings were often fuelled by a lack of social support and poverty (as with Francis), but also their consciousness of the possible long-term impact of their disrupted school attendance. This was particularly the case with older children (15-17) who were found to derive less comfort from cultural representations of a ‘good child’, and whose negative representations of their life situations related closely to their perceptions of the negative impact caregiving had had on their education. Positive meanings and emotions seemed to come from the social recognition of their responsibilities and responses to the situations they are presented with. Whilst influenced by the

social support available to them, the independence and skills gained from caregiving were also a source of positive sense-making.

Although most of the children constantly balance out positive and negative meanings of their caring experiences (dependent on context and time) the majority of children managed to construct a positive caregiver identity overall. The quotes presented in this chapter highlight the role of in-group out-group comparisons in constructing identities. However, resonating Reicher's (2004) observations, many of the children did not construct a young carer identity in a categorical sense, but in terms of their actions, beliefs and values. In *doing* identity this way, the children not only reveal their social representations of the world, but also assert possibilities of resistance and agency. It is precisely this resistance and agency, mediated by their social environment, hopeful thinking and meanings that encourage healthy psychological functioning.

To recapitulate the key findings of this chapter, Figure 13 provides a summary of the thematic network (presented in Table 18) that forms the foundation for this chapter. It is important that the summary presented in Figure 13 is read within the wider context of this study as ascribed meanings and hope are best understood with a background to the findings presented in earlier chapters.

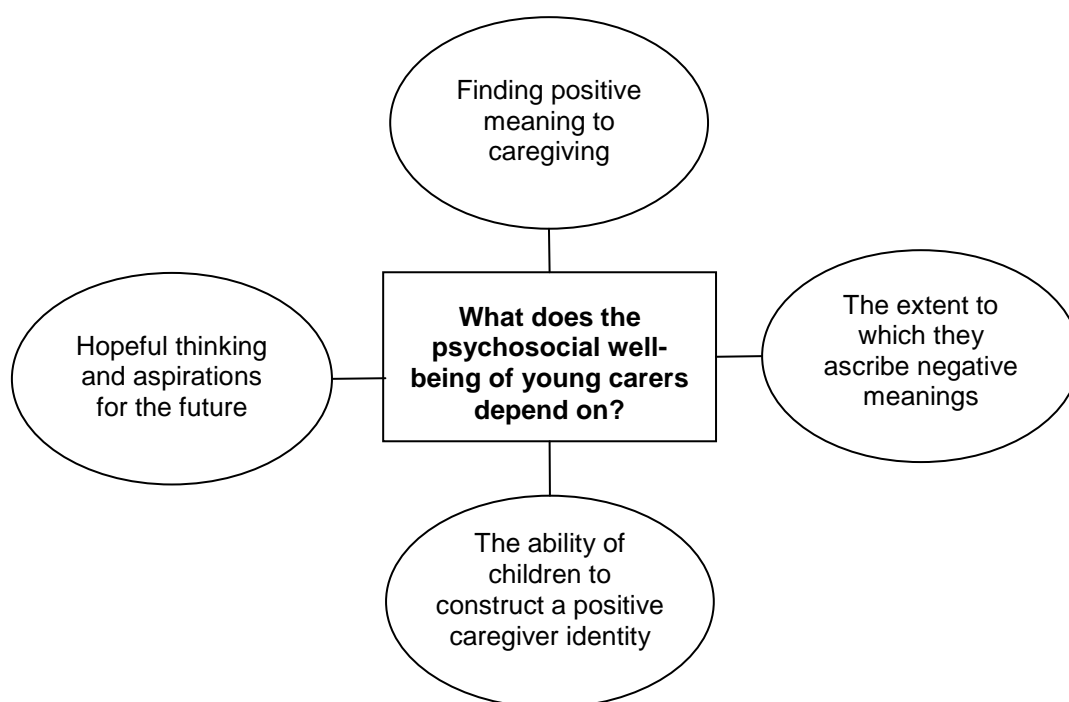


Figure 13: Summary of the psychological coping strategies of young carers

Having established the context and the social and psychological coping strategies of young carers, the next chapter evaluates an intervention which sought to facilitate and strengthen the social and psychological coping strategies discussed in Chapters five and six.

Chapter 7 - A psychosocial intervention for young carers

Introduction and chapter overview

The previous chapters have discussed and outlined the circumstances that characterise the lives of young carers, focusing on the individual-community interface in the analysis of social and psychological coping strategies. Reflecting on these findings and my conceptual framework of a social psychology of coping, this chapter seeks to explore the potential for a community-based capital cash transfer (CCCT) initiative in enhancing the social and psychological coping strategies of young carers. As discussed in Section 3.2 of my methodology chapter, the material presented in this chapter is based on the second phase of this study. The findings that I will be presenting in this chapter (see Table 19) emerged from a thematic analysis of 3 fieldworker diaries and notes, 16 essays, 21 draw-and-write essays and 10 interviews with children as well as 6 interviews with adults (see data collection procedure in Table 10, page 106).

Inspired by the PLA cycle that frames much action research (see Section 2.4.1), the intervention which I shall report on sought to build on the children's observations of their circumstances (needs, problems and social resources that facilitate coping) from phase one of this study. Through photography, daily diagrams, community maps and draw-and-write essays, the children explored their individual and collective circumstances with the aim of immediately translating these observations into action through CCCT administered by WVP Kenya. Through newly established youth clubs (see Section 3.2.4); the children were responsible for the management and implementation of their planned activities. WVP Kenya facilitated the process and provided support when needed or required. As illustrated by the thematic network for phase two (see Table 19), my interest in this intervention is to explore the impact of its process and the children's participation in strengthening the children's social and psychological coping strategies.

This chapter starts off with an overview of the intervention, its project cycle and the activities unique to each of the two youth clubs. This descriptive overview will be followed by a discussion of the children's perceptions of the project, as well as some of its more practical outcomes. Supplementing the discussion on outcomes is an account of the social psychological benefits that emerged from their participation. As Table 19 indicates, these include an enhancement of solidarity through supportive social spaces, the shaping of more empowered social identities, and an improved sense of agency and confidence in their abilities. The chapter ends with an overview of some of the difficulties the children faced during the project, with particular attention given to the role of power relations and the limitations of working with a group of children who have different agendas in relation to the project, different expectations of what they shall achieve and varying conceptions of how to behave.

Table 19: Global theme: Process and impact of CCCT

Organising themes	Basic themes identified	Issues discussed	Codes
Project process and content (discussed in Section 7.1)	58. The children had different abilities and interests which influenced their roles and responsibilities in the project.	<ul style="list-style-type: none"> • Decision making • Skills focus • Labour • Gender • Committee members 	- Division of labour and roles (15 children, 1 adult)
	59. Time constraints and distance meant retention was an issue.	<ul style="list-style-type: none"> • Distance • Lack of time • No immediate benefits 	- Drop-outs (18 children, 3 adults)
	60. The children strategically involved some guardians in the project to ensure its success.	<ul style="list-style-type: none"> • Called for advice and guidance • Do work whilst children are in school 	- Parents invited (10 adults, 23 children)
	61. The Moja project involved selling of maize.	<ul style="list-style-type: none"> • Permission to participate • Selling of Maize • Profits 	- Moja project (11 children)
	62. The Mbili project involved gardening, poultry keeping and purchasing of school uniforms.	<ul style="list-style-type: none"> • Purchasing of equipment • Growing of Kale • Selling of vegetables at market • Poultry keeping and chicken shed construction • Purchasing of school equipment 	- Mbili project (48 children)
Materialistic and practical outcomes (discussed in Section 7.2)	63. The children have a balanced view of team work, its benefits and limitations.	<ul style="list-style-type: none"> • Skills transfer • Sharing eases work load • Different agendas and interests 	- Team work (50 children, 1 adult)
	64. The children observed a number of benefits from working together.	<ul style="list-style-type: none"> • Generating more ideas • Work faster with more hands • Gain confidence in skills 	- Achieving more as a team (14 children, 2 adults)
	65. The children benefited materially from the project.	<ul style="list-style-type: none"> • Money • Food • School related materials • Chicken 	- Materialistic gains (40 children)
	66. The children have benefited from new coping facilitating skills.	<ul style="list-style-type: none"> • Poultry keeping and gardening • Running a business • Synergy of skills and knowledge 	- Skills learnt (32 children, 4 adults) - Skills share and transfer (34 children, 2 adults)
	67. There has been a wider impact of the children's participation in their community.	<ul style="list-style-type: none"> • The community benefits from the availability of vegetables • Child-to-child education • Sharing of knowledge and skills 	- Community project benefits (6 children) - Wider impact (21 children, 4 adults)
Social Psychological benefits (discussed in Section 7.3)	68. The project facilitated the development of supportive social spaces based on a strong sense of togetherness and unity.	<ul style="list-style-type: none"> • Sharing of problems • Coming to a resolution • Peace, love and unity 	- Psychosocial support from friendships (19 children)
	69. A number of children changed certain behaviours and attitudes as a result of their participation – including their sense of identity.	<ul style="list-style-type: none"> • More social and proactive • Maturity • Respectfulness • Accepting carer role 	- Behaviour change (8 children, 4 adults) - Reshaping identities (7 children, 1 adult)
	70. For some children, the project led to an increased sense of empowerment and control.	<ul style="list-style-type: none"> • Adults accept child ownership • Self-confidence/self-efficacy • Independence and control • Stronger and more proactive 	- Project ownership (1 child, 2 adults) - Empowerment (15 children, 4 adults)
	71. Many children had expressed hope for the future as a result of their participation in the project.	<ul style="list-style-type: none"> • Youth groups and unity • Skills learnt and knowledge gained 	- Future impact on project (8 children, 3 adults)
Difficulties and challenges (discussed in Section 7.4)	72. On occasions the parents involvement in the projects undermined the children's efforts.	<ul style="list-style-type: none"> • Refuse children's participation • Involuntary involvement 	- Negative parental involvement (14 children)
	73. Some children felt that the project committee were to blame for problems faced.	<ul style="list-style-type: none"> • Corruption • Power • Lack of respect • Theft 	- Committee causing problems (16 children, 1 adult)
	74. The children experienced some difficulties in managing the profits.	<ul style="list-style-type: none"> • Safe keeping • Management 	- Profit issues (5 children)
	75. Laziness and differences in work ethics was prevalent.	<ul style="list-style-type: none"> • Laziness • Excuses • Only want to benefit but not work 	- Work ethics (27 children, 3 adults)
	76. The children occasionally got into conflicts and disagreements.	<ul style="list-style-type: none"> • Fights and disagreements • Unequal workload and share • Laziness 	- Conflict (6 children, 1 adult) - Non-team players (4 children)
	77. Theft was a problem for both projects.	<ul style="list-style-type: none"> • Theft by parents • Theft by fellow participants 	- Theft (29 children, 1 adult)
	78. The children observed ways to solve problems and in which the programme could improve.	<ul style="list-style-type: none"> • Dialogue and involvement • Problem solving 	- Recommendations (40 children, 5 adults)

7.1 Project process and implementation

In Section 2.4.2 I described the theoretical underpinnings and process that characterise CCCT. In this section I outline how WVP Kenya adapted CCCT (previously implemented with and by adults) to a context that sought to target children in an effort to empower and strengthen their existing coping strategies. To do so, I will draw on the themes and issues presented in Table 19, elaborate in detail the process through which the project was implemented. To guide this descriptive narrative, I adapted the CCCT diagram presented in Section 2.4.2 and identified 5 key steps (see Figure 14) that characterise the PLA cycle latent to this project, each of which will be described in turn. However, before I do that I will provide a brief overview of the genesis and mobilisation of the two youth clubs.

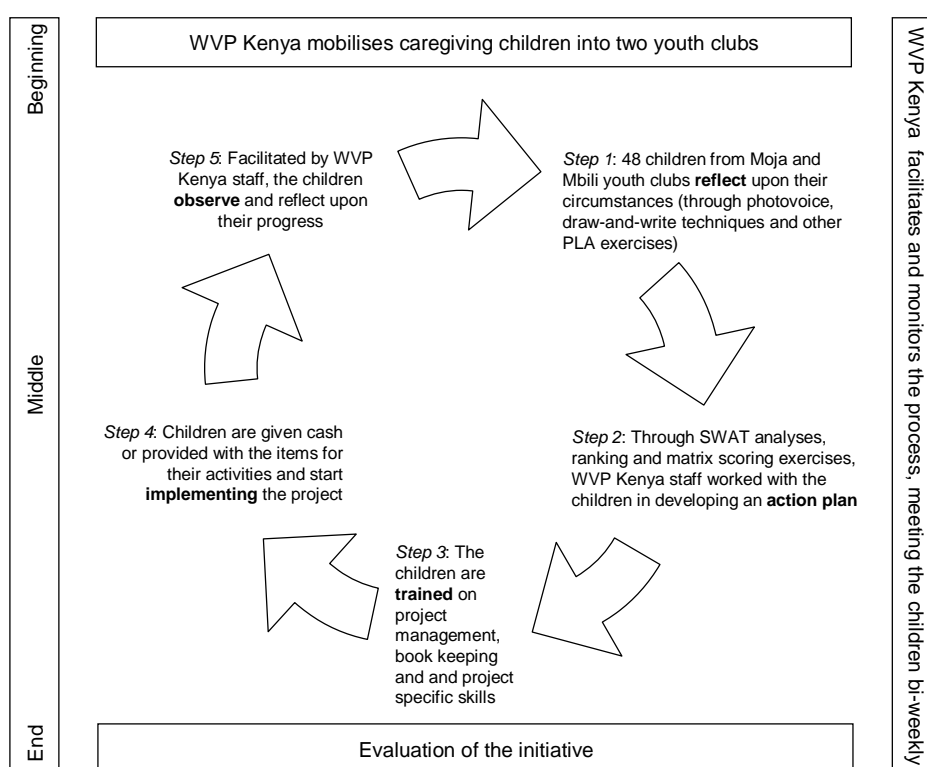


Figure 14: Participatory learning and action cycle used in this study

As a vital component of this action research project, considerable time was spent in setting up the CCCT initiative. Following the recruitment of 48 young carers from Moja and Mbili communities by community guides, WVP Kenya mobilised and gathered the children for an introductory workshop. In this workshop the children were introduced to the project, each other and to the research assistants and social workers facilitating the project. With 24 children in each community, the first couple of months of the programme were spent encouraging the children to meet on a weekly basis and in generating a sense of group identity. The groups were referred to as 'youth clubs' and staff from WVP Kenya visited the clubs on a weekly or fortnightly basis. Without the facilitation of WVP Kenya, the youth clubs set up their own committees, consisting of children participating in this study, who were democratically elected. The committees had a chair person, a treasurer and a

secretary, as well as assistants to these three positions. To be elected, the electors had a number of informal criteria, mostly referring to the nominee's active participation and personal attributes.

"... based on attendance and activeness. We checked how active the nominees were and whether they participated in group discussions." Carolyne, 15 (Mbili/Interview)

The youth clubs were provided with equipment for volley ball and football as well as paper and coloured pencils for those wishing to engage in more creative activities. The children met in a location central to their particular geographical community. The Moja youth club met on the grounds of an active community member and the Mbili youth club met on the grounds of a nursery, with club equipment, such as volley balls and net, being brought in by the committee members. It was through these weekly (sometimes fortnightly) meetings that the PLA workshops took place, generating data for this thesis and facilitating the implementation of CCCT with the children.

7.1.1 Reflections (step 1)

One of the most important steps of a PLA project cycle is to facilitate reflection in a way that brings forward collective needs and solutions. WVP did this through a series of PLA workshops involving activities including community mapping, daily diagrams of their daily activities and commitments, a time line of their own history profile, photovoice and essay writing (see Table 20). These PLA methods have been described in detail in Section 3.2.4. The workshops were facilitated by fieldworkers Vincent and Cellestine who work for WVP Kenya and serve as the local investigators of this study. The activities and discussions they had with the children provided them with an opportunity to get an in-depth insight to the lives of young carers in this context. Table 20 summarises the activities, their purpose and the outcomes of each of the workshops.

Table 20: Activity summary of Step 1 (Reflection)

When	Activity/workshops	Purpose	Outcome
May 2007	Daily diagram workshop – facilitated by WVP Kenya staff. Each child drew a daily diagram	To encourage the children to reflect upon their caregiving in a daily context	- 48 daily diagrams - Children put their caregiving duties into perspective
June 2007	Historical profile workshop – facilitated by WVP Kenya staff. Each child drew up their historical profile	To encourage the children to reflect upon their caregiving in a historical context	- 48 historical profiles - Children put their caregiving duties into perspective
June 2007	Community map workshop – facilitated by WVP Kenya staff. In groups of four, the children collectively drew up a community map.	To allow the children to discuss, share and reflect upon their context, including who and where they can get support	- 12 community maps - The children shared with other children sources of support - Maps provided WVP Kenya staff with reference points
July 2007	Photovoice workshops – i) purpose, ethics and use of cameras, ii) Photovoice essays, draw-and-write essays, iii) Collective sharing of photos and reflections	To allow the children to identify, represent and enhance their community and circumstances	- 240 photographs and drawings, each accompanied with a written narrative - Descriptions and reflections about their circumstances

7.1.2 Preparing an action plan (step 2)

After a series of PLA exercises, the children were gathered to synthesise and make use of their reflections in developing an action plan. To facilitate this process, a brainstorming of activities which they believed could address some of their collective needs was carried out. Numerous activities came to light, including goat keeping, rabbit keeping, farming, selling of paraffin, selling of maize, purchasing of school equipment and poultry keeping. In discussing each of the proposed activities, Vincent and Celestine constantly referred back to their discussions with the children in earlier workshops (see step 1), exploring how these activities could i) address some of the immediate and collective needs and ii) best utilise the social resources and coping strategies available to them. Using SWOC analyses (looking at Strengths, Weaknesses, Opportunities and Constraints of each activity), Vincent and Celestine managed to narrow down the potential activities and helped the children rank the activities according to their impact and feasibility.

With a short list of potential activities, the children went into their communities and did some research on each of the activities and decided which one of their short-listed activities they would want to do. Although Vincent and Celestine had been advising and supporting the children in developing a budget, the children did at this stage still not know how much money would be available to them.

In a subsequent workshop, the children were provided with a proposal template (see Appendix 20) in which they could develop their group action plan and translate it into a proposal. Whilst no conditions as to how the money should be spent were imposed on the children, they were strongly encouraged by Vincent and Celestine to include income generating activities that work for a collective cause rather than spending the money on individual items. At this stage, the children were also informed of the financial limits of possible activities, being told that the amount requested should not be larger than a total equivalent to €50 per active child. With this new information, the children knew how many of their ranked activities they would be able to implement and therefore only wrote up proposals that could be covered with the money potentially available for allocation. The reasons why information about the potential allocation had not been provided to the children prior to this workshop were two-fold. Firstly, WVP Kenya wanted the children to have action plans that they could implement after, or in addition to, the funded activities, encouraging the children not to be reliant on NGO support. Secondly, if the children knew there would definitely be money available to them, this could have had an impact on project retention, with children participating solely because of the financial reward and therefore 'selling' their stories and personal accounts – which could arguably be considered unethical.

In a final workshop with each youth club, budgets and work-plans were discussed and finalised. A total of four proposals were submitted by the children. These will now be described followed by a summary of the activities carried out in step 2 of the PLA project cycle (as listed in Table 21).

Moja youth club

By the time the children had to finalise their proposal, only 14 children (out of 24) remained in Moja youth club (reasons for drop-outs will be discussed later), qualifying them to receive €700 (Ksh 70,000) as a group. With that amount available, the Moja youth club could only submit one proposal and applied for money to set up a maize selling business. The aim of this business, as articulated in their proposal was to give them entrepreneurial skills and knowledge.

“We hope that through maize selling, each and every individual shall gain knowledge on how to operate his/her own business and we therefore hope that after this project, each member shall get his/her own income.” Young carers (Moja/group discussion)

In preparation for this activity, the children had consulted women at the nearest market centre about the costs and profits involved in selling maize. Their investigation revealed, as they noted in their proposal, that they predicted profit of ksh 150 (€1.50) per sack of sold maize which is purchased for about ksh 1,500 (€15), not accounting for the discount given to bulk buys. As Samuel explains below, the children of Moja decided to start off the project by buying 40 sacks of maize.

“When we started this project of selling maize we agreed that we should start with forty sacks which we could get at the cost of ksh 54,000. We saw our maize being transported by a lorry to the market to confirm that the forty sacks of maize arrived there. We hired a store at market centre and discussed how we should start selling the maize. We agreed to buy tins for measuring 1 kg and 2 kg of maize and a piece of plastic to spread and dry the maize before selling.” Samuel, 13 (Moja/draw-and-write, no drawing available)

Mbili youth club

Unlike the children from Moja, the children from Mbili had not previously been subject to NGO support. The children were therefore unsure about what they could expect from the partnership with WVP Kenya and this may be the reason why they had planned more modest activities. The children of Mbili were therefore able to submit three proposals, one on poultry farming, one on kale growing and a final one to buy school related equipment. However, before these three proposals were finalised, Vincent and Cellestine had to provide additional support to guide them on the importance of collective and income generating activities that included a participatory learning process. Nevertheless, the children of Mbili were adamant that school related equipment was their biggest need and totalling Ksh 23,720 or €237, the proposal on school related equipment (uniforms, books, shoes, calculators etc) was the most expensive project. As the proposal for school equipment was well within the funds available, Vincent and Cellestine decided not to reject the proposal, but in addition fund the more collective and income generating activities that featured second and third on the list of activities to be actioned. As said above, the two additional proposals coming from Mbili included kale farming (at Ksh 12,980, or €130) and a proposal on poultry keeping (at Ksh 9,300, or €93). In preparation for these proposals, the children had to negotiate access to land for farming and to house the chicken-shed and calculate the logistics of these activities, including distance from a water source, costs of equipment required and the role of their guardians in these activities.

These proposals were accepted as OK by WVP Kenya, and the children went ahead and actioned all three activities.

Table 21: Activity summary of Step 2 (Action Plan)

When	Activity/workshops	Purpose	Outcome
Sept. 2007	Learning from reflections workshops – facilitated by WVP Kenya staff in each of the two youth clubs	To encourage the children to think of activities they could do, informed by their own observations and reflections	- Identification of a series of activities which the children believe address common problems - Identification of local resources
Sept. 2007	Agreeing on an action plan workshops – facilitated by WVP Kenya in each of the two communities using ranking and scoring techniques	To rank the activities they have identified according to their collective impact and feasibility – informed by SWOC analyses	- Ranking matrix of activities - Agreement amongst the children
Oct. 2007	Workshop on translating the action plan into a proposal before submitting it to WVP Kenya	To teach the children how to write proposals and to give WVP Kenya a chance to scrutinise the proposals before approval	- Children learnt how to write a proposal and a budget - 4 proposals were submitted to WVP Kenya
Nov. 2007	Finalising of the proposals workshop – facilitated by WVP Kenya immediately before their approval	To go through the action plans and collectively amend areas of concern	- Both children and WVP Kenya staff were confident in the activities planned by the children. - 4 proposals were approved

7.1.3 Training and skills building (step 3)

Before cash was transferred to the children, or purchases made on their behalf by WVP Kenya, the children were trained in book keeping, project management and on topics specific to their planned activities (see Table 22). A series of workshops, facilitated by Vincent and Cellestine in the two communities, covered all the basic principles of project management and book keeping. The primary aims of these workshops were to ensure the children implemented the activities to the best of their abilities and for them to have a clear overview of the money coming in and going out, profits made and what they could potentially do with the profits.

Moja youth club

In addition to the above workshops, two trainings on business management and maize selling were conducted with the children by a local facilitator.

Mbili youth club

As a result of the diverse selection of activities implemented by the children of Mbili, more training workshops had to be conducted. Training workshops on kale farming, poultry keeping and the construction of local chicken sheds were conducted with the children. A facilitator from the local district department of agriculture taught the children about kale growing, poultry farming and diseases as well as how to build a chicken shed using locally available materials.

Table 22: Activity summary of Step 3 (Training)

When	Activity/workshops	Purpose	Outcome
Dec. 2007	Project management and book keeping workshops – facilitated by WVP Kenya staff in each of the two youth clubs	To introduce to the children basic principles of project management and book keeping	- Children become aware of project management principles and expectations of WVP Kenya
Dec. 2007	Project specific trainings – co-ordinated by local facilitators	To give the children the skills to adequately and successfully implement their activities	- Children gain skills relevant to their project(s)

7.1.4 Project implementation (step 4)

Before cash was transferred and items purchased, each youth club had a session with Vincent and Cellestine to plan their implementation of activities (see Table 23). Like in many of the other workshops, this involved a brainstorming of ideas and procedures, with Vincent and Cellestine guiding their ideas into a feasible work plan. By the end of January and beginning of February 2008, the children were ready to start the implementation.

Table 23: Activity summary of Step 4 (Implementation)

When	Activity/workshops	Purpose	Outcome
Jan. 2008	Work plan workshop – facilitated by WVP Kenya in each of the two youth clubs	To allow the children identify the steps involved in implementing their activities	- The children get some structure to their programme
Jan/Feb 2008	Transfer of cash and items purchased	The children are provided with cash and items to implement their activities	- Children have control over the implementation of the project
Jan.'08 - present	Monthly follow-up visits by WVP Kenya staff	To ensure the children have access to guidance and support where and when required	- Children are given the opportunity to seek support

Moja youth club

As stated earlier, the children of Moja had decided to do maize selling. As this project required a large one-off buy of maize, the children asked Vincent to go and pay for the maize at the wholesale store. The children said they would feel uncomfortable walking with a large amount of cash. In the company of a couple of children, Vincent placed the order and a few days later, the maize was transported to Moja market town. Here the children had negotiated access to a storage facility in the local PO Box office (see Picture 45). Also as part of their preparation for the project, the children had arranged and prepared a rota for three guardians who had agreed to help out and take charge of the maize selling. The children decided to involve these guardians in order not to disrupt their schooling. In return, these guardians could buy the maize at a 'wholesale' price for private consumption. Whilst this appeared to be a sensible move, the involvement of guardians in Moja turned out to be a contentious issue, with one guardian stealing a large amount of money. Section 7.4 of this chapter will attend to this issue.



Picture 45: Guardian showing the maize business

The revenue from the sale was collected and kept by the youth club treasurer. Whilst this project was not expected to generate more than Ksh 6,000 (€60) net profit, the experience of managing the business and reinvesting the overall profit into other activities, in order to gain more diverse business experiences, was seen as a primary aim for the children. So although the children implemented this project collectively, they saw it as a springboard to gain new skills and knowledge, both from the experience and from their peers, which would lead to other and more self-reliant entrepreneurial activities. In light of limited net profits and materialistic gains, this seems to be a realistic aim.

Mbili youth club

A different process was followed at Mbili. With 15 children still active in the programme at the start of implementation, they qualified for Ksh 75,000 (€750). With support from WVP Kenya, they decided to divide the money and take ksh 5,000 (€50) each and individually distribute the money to the three planned projects (kale growing, poultry keeping and school equipment). This agreement was made between the children so that they could go out and buy their own school equipment and chicken. They added the remaining money into a collective fund wherefrom the chicken shed and the kale growing activities could be funded. This process is described by 12-year-old John, who also explains how some children, using the money at their discretion, opt to spend less on school equipment for themselves in order to spend some of their money on their household.

“Because it was during a time of hunger, I used part of the money to buy maize for my household and the remaining money, I used for buying school items like school uniform and school shoes. I also bought two hens and the rest of the money was used in the collective activities.” John, 12 (Mbili/draw-and-write, see Picture 46)



Picture 46: Draw-and-write picture by John, age 12

With three approved action plans, the children of the Mbili youth club knew they had to get organized and share responsibilities. Twelve-year-old Kevin provides an account of how they went about implementing their activities.

“Now we started by clearing the farm where we wanted to grow vegetables and also a plot where we wanted to construct a poultry house. Now every Sunday morning we used to meet in Joyce’s home to implement our activities. Because we have been taught how to grow vegetables and the best type to grow, we went straight ahead preparing the vegetable farm. We later started constructing the poultry house and at that time, we agreed to share the responsibilities. Some collected manure and others were constructing the poultry house [...] after we had bought all the materials, we then went to Bondo to buy vegetable seeds, water cans, chemicals and a sprayer. We started by growing cow peas, sold them and then used the money to buy sukuma wiki seeds. We planted sukuma wiki in nursery bed and watered them.” Kevin, 12 (Mbili/draw-and-write, no drawing)

As in Moja, guardians were being tremendously supportive of the activities and helped the children water their farms during dry spells and when the children were in school.

7.1.5 Observations and recommendations (step 5)

To ensure the smooth running of the activities and to help the children overcome any obstacles they may encounter in the process, WVP Kenya ran a number of workshops that sought to help them reflect upon the process as well as on positive and negative outcomes (see Table 24). One such workshop, exploring the effectiveness of their collective efforts, was carried out half way through the

project. In this workshop the children present were asked to write an essay about being part of a team, with the context being their project and colleagues. The children could then volunteer and share their observations, giving rise to discussions about some of their difficulties, as well as building confidence (or not) in their collective efforts.

Although the activities are still running and active, towards the end of the research project in November 2008 a series of evaluation workshops were carried out, using draw-and-write techniques (see Appendix 7) and individual interviews. The draw-and-write essays were also shared amongst the children. These essays and interviews all form part of the findings that will be presented in the forthcoming sections.

Table 24: Activity summary of Step 5 (Observation)

When	Activity/workshops	Purpose	Outcome
April 2008	Reflection workshop on being part of a team	To uncover the benefits, issues and difficulties in working together	- An opportunity to intervene where problems have arisen - Gain insight to the impact of group work
Nov/ Dec 2008	Participatory evaluation – facilitated by WVP Kenya with children and adults in each of the two communities	To give the children a chance to communicate their observations of the project, allowing WVP Kenya to address some of the observed problems in consultation with the children	- Insights to problems faced by the children - Insights to the impact the activities have had - Insight to how the activities can move forward, possibly repeating the project cycle

7.1.6 External factors impacting on project process

There were a number of external processes that influenced the activities implemented by the children. The external processes most frequently reported by the children referred to the involvement of guardians in their activities as well as retention. Drawing on the children's accounts and field notes, I will discuss these two external factors in turn.

As elucidated earlier in this thesis, despite the fact the children are perceived both as active and competent participants in community life; they are also at the bottom of a hierarchical power relationship where adults have the final say. As a result, their guardians' support and acceptance of this project was paramount. This is reflected in a comment by Pascal who reported that their guardians allowed them to take the time and participate in these activities.

“Our parents also give us enough time to come together or to do our activities.” Pascal, 14, (Moja/Draw-and-write, see Picture 47)



Picture 47: Draw-and-write picture by Pascal, age 14

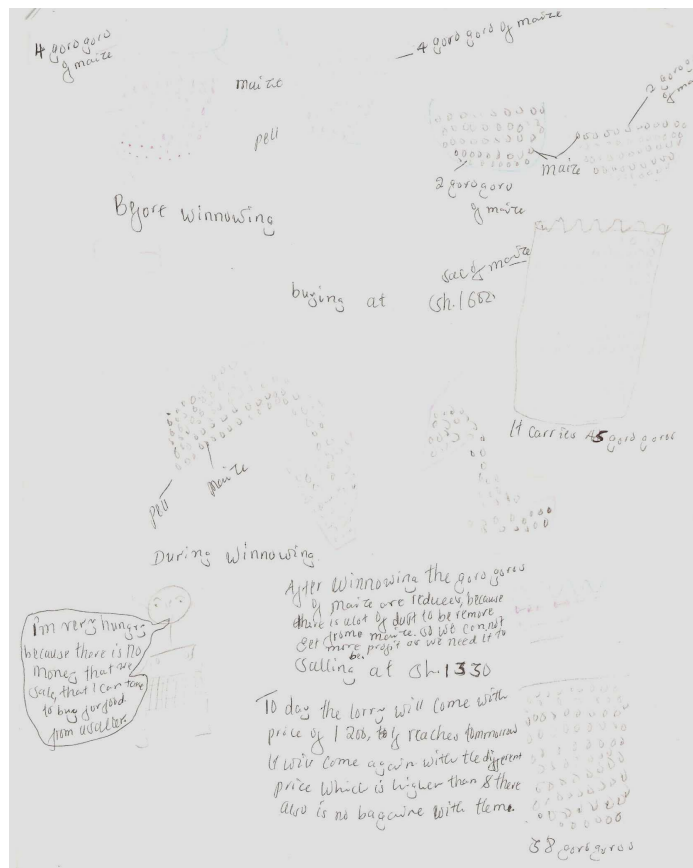
But perhaps more importantly, guardians wielded great influence on the project through their involvement in the project. The children's school commitments meant that guardians from both communities got involved in the implementation of the programme and assisted with aspects of the activities initiated by the children.

"Now during school days, it is our parents who normally care for our farm as well as our poultry." Everline, 14 (Mbili/draw-and-write, see Picture 48)



Picture 48: Draw-and-write picture by Everline, age 14

“In our team work you find problems that be solved by the leaders of the group (i.e. by child participants). But some of the more serious problems we might not be able to solve as a team unless we involve some parents and the co-ordinator.” Debora, 15, (Moja/draw-and-write, see Picture 49)



Picture 49: Draw-and-write picture by Debora, age 15

The involvement of some guardians was for the most part a choice made by the children. And as exemplified above, they knew when (during school days) and where (problem solving) to involve their guardians. The above quotes also illustrate that the children were aware of some of their limitations as children (e.g. having to go to school) and the benefit of having someone with more authority to guide them through problems. While the children of Mbili sustained a good and working relationship with their guardians, the children of Moja experienced a number of difficulties as a result of their guardian’s involvement. I will turn to these difficulties later. Although the children chose to involve some guardians in the project, many adults believed that the children would have benefited more from these activities had the parents been involved more formally. This was articulated by one guardian.

“Though it was for children we were to guide them on what to buy and what not to buy. If that could be done, the children would have not done what was not required or buy items with a higher price as they did. Now my request is that in case there is another programme to be started, the parents/guardians should be very close to the children so that they can guide them.” Female adult14 (Mbili/interview)

Such notions are indicative of the power relations that exist between adults and children in this context. Nevertheless, it is evident that the children made use of the support available from their guardians by inviting them to participate. While the involvement of guardians has had a very supportive impact, there were a few guardians who took advantage of their invite and did more than the children had agreed to. These experiences will be discussed in the final section of this chapter.

A number of external factors had an impact on the retention of participants. Whilst the youth clubs started with 48 participants, after 21 months, participation had dwindled to 28 (see Table 8, page 99). I now turn to discuss possible reasons for low retention.

One external factor impacting on the activities was the geography and longitudinal nature of the project. The geographical spread of the children involved in each youth club impacted negatively on project outcomes. For some children, the long walk to the weekly meeting place was both time consuming and tiring. This, coupled with the caring of a parent, meant that retention of club and project participation was difficult with children slowly dropping out.

“Enoka did not join us in the programme and in doing the activities because his mother was sick and he had to care for her. He was also staying far away, making it difficult to communicate with him.” Samuel, 13 (Moja/Interview)

Parental death also had an impact on retention. Children in Bondo are highly mobile and many children migrate upon the death of their parents or guardians in search for alternative fosterage arrangements. Kevin attributes such circumstances to the issue of retention.

“Some children, like Beryl, are no longer around. After the death of her mother, she left.” Kevin, 12 (Mbili/interview)

As Table 20 and Table 23 indicate, it took 8 months from the first workshop (May 2007) until the activities were implemented (January 2008). As the initial workshops did not suggest that support was to come their way, the children who got involved in this project because they believed that their involvement with the NGO would lead to material benefits, left the programme prematurely as they found no material gains from their participation. As 14-year-old Pascal allude to, this was either on their own initiative, or pushed for by their guardians who felt that their time and efforts would be better spent elsewhere.

“At the beginning, we were 24 but some felt it was a waste of time and decided to leave the programme. Now we are 14 people left. They also dropped out because they felt that other organisations would also give support to their guardians and some guardians encouraged them to leave the programme because they did not immediately benefit.” Pascal, 14, (Moja/interview)

Pascal's observation about children dropping out because of limited gains was also noted by Vincent and Celestine in their field notebooks. These observations highlight how children actively select support in ways that optimise their time and efforts.

Nevertheless, it is evident that geographical distance, the longitudinal nature of this project, coupled with no immediate gains and other duties assumed by young carers, as well as migratory forces, have all contributed to low retention. These factors were further exacerbated by the post-election conflict that took place in Kenya between January and March 2008 (also mentioned in Section 3.2.1), which first meant the children could not leave their households and subsequently had to attend school during weekends to catch up lost school-going days, compromising the time they had available for their project.

This section has introduced the two youth clubs and shown what activities the children got engaged in through a CCCT initiative. The specific processes of these two initiatives have been outlined, followed by a discussion on two of the most prevalent external factors identified to impact these projects. The forthcoming sections report on findings from step 5 of the PLA project cycle, exploring some of the outcomes and perceptions of the project as identified by the children.

7.2 Children's accounts of project outcomes and perceptions

This section explores some of the many outcomes and perceptions that were articulated by the children. As illustrated by the themes 63-67 in Table 19, these range from an awareness of team work qualities to material gains and attaining coping facilitating skills, which were also observed to have an impact on those around them. Discussing these outcomes in turn, the first subsection explores some of the important insights gained by the children on the qualities and benefits of working together, exercising solidarity. This will be followed by a discussion of some of the more practical and materialistic gains and coping skills that the children reported to benefit them and their wider community.

7.2.1 Awareness of team work qualities

The children had a realistic view of the possibilities and limitations of group and team work. Their views were generally varied, speaking both of the positives and negatives of group work, and often did so in relation to one of their experiences. Nevertheless, being aware of the possibilities and limitations of group work, 15-year-old Michael summarises neatly his perception of group work.

"We have been working together so that we share, but there must be advantages and disadvantages of everything good. As we were starting the project we experienced some natural problems." Michael, 15 (Mbili/essay)

This pragmatic view of facing 'natural problems' was held by many children and likely to be a reflection of their own, or their guardians', previous life experiences (e.g. from community groups,

family life or school). Aware of the many different community groups that characterise the social landscape in Bondo, as well as the benefits of working together, the children drew on these experiences and observations to make sense of their own group experience. Fourteen-year-old Pascal, for example, highlights how his meaning and understanding of group work is partly a reflection of his observations of group work elsewhere.

“Being in a group teaches people how to talk to other people. It can also change lives. Being part of a team and this youth club has changed my life as I can now share problems with others and we can solve them together. I have seen many people benefit from working in teams and now I’m part of a team and experiencing many of these things myself. Mostly they are good things and being part of the team is very good to people as it creates respect amongst people.” Pascal, 14 (Moja/essay)

Pascal also talks about the kind of respect and solidarity team work can generate. He speaks of his experience as life changing, now knowing people whom he can share his problems with and who understands these problems. For many children, the realisation of exactly how much more efficient team work is, both in terms of the time spent on work as well as the volume, has been beneficial. Twelve-year-old Kevin reports on such an observation and the skill-sharing that he learnt team work can bring about.

“The idea of working together is good because many hands make work a lot easier. I have learnt that by working together with other people you can learn new things.” Kevin, 12 (Mbili/essay)

Facilitated by this skills-sharing process, the majority of children reported on team work as a route to gain invaluable experience and knowledge on how to achieve greater independence from parents and guardians, often through their own income generating activities. This became evident from the reflections of 15-year-old Florance who in an essay on team work writes about her experiences of working in a team and running a maize selling business.

“From being part of a team I have learnt that we can help ourselves without asking our parents to give us things that we lack of. I have also learnt how to do small business from this team.” Florance, 15 (Moja/essay)

Some children also reported on their activities as a route to develop the community and to empower youths. This was well articulated by 16-year-old Zeddy from Moja youth club.

“When you do something together, you can bring development in the community even if you are young children.” Zeddy, 16 (Moja/interview)

As the coding framework in Table 19 alludes to, the majority of children found team work to be a rewarding and eye-opening experience. This is an important outcome as the children are more

likely to engage in collective activities in the future if they have experienced first hand the benefits of team work. But what are some of the more practical benefits reported by the children?

7.2.2 Practical impact on self and community

At a material and practical level, the children benefitted from an increased access to money, food, school related materials and chickens. They also benefitted from new and practical skills that could facilitate their coping, which they said would serve to help both themselves and their communities in generating income and passing over their newly acquired skills to others.

In the 10-month-period from project start (January 2008) to this evaluation (November 2008), the children from both youth clubs generated some profit. In Moja, the money earned from maize selling provided many of the participating children with much needed resources to buy day-to-day items which they would otherwise struggle to buy. These included paraffin (for lamps so they could study at night), matches, and bars of soap, clothes and food. Many children from Moja also chose to spend profits made from maize selling on as school equipment as exemplified by 15-year-old Florance.

“As a result of our project, I can now buy some clothes, uniforms, shoes, food and a school bag. The money we earned from selling our maize. Some of us do not have those things that I mentioned, but now we are able to buy them.” Florance, 15 (Moja/essay)

As most young carers live in destitution, getting a new school uniform allows them to look like non-caring children. This might explain why children like Florance in Moja decide to spend their hard earned money on school uniforms and why one of the proposals from Mbili was on school related equipment, including uniforms. In accordance with their proposal, all 14 participating children in Mbili bought a new school uniform, relishing a rare opportunity:

“I never imagined putting on a full school uniform, including school shoes and a sweater, because my mother was seriously sick and couldn't afford it.” Joyce, 12 (Mbili/essay)

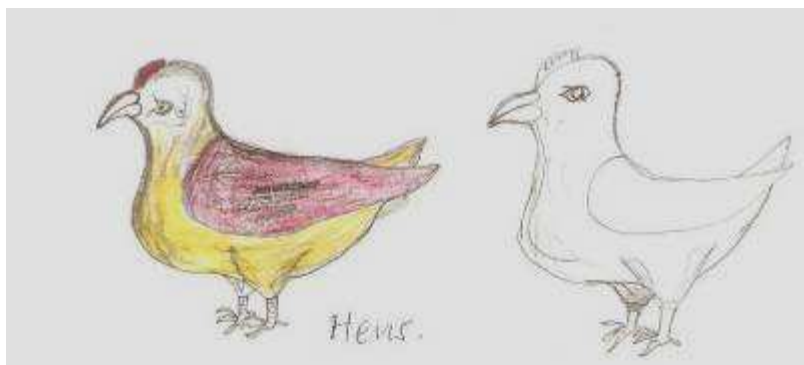
Aside from benefiting from increased access to financial resources, the children also benefited from new coping resources, such as gaining entrepreneurial skills. Reflecting on the maize selling activity in Moja, 14-year-old Jael for example reports on having learnt how to run a business and make profit.

“What I have learnt from working as a team is that I now know how to run a business and also how to calculate profit. It is also good because we share ideas and different thoughts on how to expand the business.” Jael, 14 (Moja/essay)

Jael also mentions how, as a team, they shared ideas that would help them make their business successful. Similarly, in Mbili, the children, both from working together and through training

workshops, gained many different skills, tips and ideas that further strengthened their ability to cope with adversity.

“What I have learnt from working together is that I now know how to grow vegetables as well as poultry keeping. By working together, I now know the poultry diseases and how to cure them. I’ve learnt the vegetable diseases and how to cure them.” Kevin, 12 (Mbili/draw-and-write, see Picture 50)



Picture 50: Draw-and-write picture by Kevin, age 12

Through the duration of this project, the children’s guardians have witnessed these newly acquired skills in practice. Three of the six guardians interviewed for this evaluation reported on the change they had seen from their children. These, as the adult below comments, range from noticeable behaviour change to being more competent in their engagement with coping facilitating activities such as food and income generating activities.

“I have benefited in that my child can now keep poultry, he also knows how to grow vegetables. He does not have time to play around and instead, he goes to their programme where they carry out the activities. Now when our poultry are having diarrhoea, he knows what the chickens are suffering from. For those reasons, I have really benefited a lot.”
Female adult13 (Moja/interview)

These skills, as well as the activities implemented through the CCCT initiative, meant that some children felt more capable of providing care for their sick guardians. Seventeen-year-old Jane for example said “the activities also supported me in caring for the sick person that I was looking after.” Aside from their guardians, the siblings of the participating children were also reported, both by children and adults, to have learnt from their commitment and hard work. Many children spoke of a heightened interest within their community in the programme and the skills they had learnt as a result. This interest resulted in significant skills transfers to siblings, neighbours and guardians, giving the children a powerful role as facilitators of development (as opposed to passive recipients) within their communities.

“It has also helped my household in that they now know how to keep poultry as well as growing vegetables using the knowledge that I got from this project. My family has planted

vegetables and is now planning to keep poultry just because they saw what we did in our project. This has encouraged some of our neighbours to contact me, asking me how to keep poultry and how to care for them.” Carolyne, 15 (Mbili/draw-and-write, see Picture 51)



Picture 51: Draw-and-write picture by Carolyne, age 15

It is evident that these activities have had a strong positive impact on some of the children, enabling them to gain access to many more practical resources. As this section has shown, these resources ranged from monetary, material benefits (e.g. school uniforms and shoes) and *savoir faire* (e.g. business skills, poultry keeping, and vegetable farming) to social psychological resources (e.g. self-esteem, empowerment and perceived competence materials). The next section will explore the social psychological resources in greater detail.

7.3 Social psychological benefits of participation

As the previous sections have demonstrated, the CCCT process provided the remaining children with an opportunity to participate in activities which had practical benefits for themselves and often also for those around them. This section of the chapter seeks to explore some of the symbolic and social psychological resources that emerged from the children's participation in the youth clubs and CCCT activities (themes 68-71 in Table 19). These include the role CCCT played in enhancing supportive social spaces, solidarity and unity, a shaping of social identities, agency and awareness of local strengths.

7.3.1 Supportive social spaces

In Section 2.3.5 I spoke of the importance of supportive social spaces for vulnerable people to cope with adversity. For many of the participating children, the youth clubs constituted such a space. It was a space where the children could 'hang out' and have fun with children of similar circumstances, which made some of them feel more united. Additionally, in this space the children could freely share stories and coping strategies, making the youth clubs worthwhile and according Francis, enjoyable.

"Being part of a team is that it is quite enjoyable because we do things together socially and learn new things which can help us get by. We share ideas and work together." Francis, 14 (Mbili/essay)

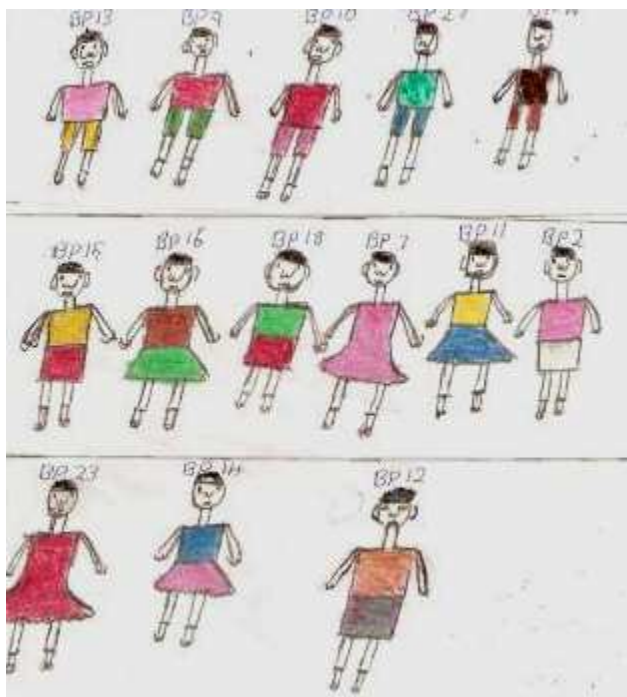
"Being together and sharing stories makes us to feel united and have peace between us and other people who are in the community." Michael, 15 (Mbili/essay)

The social spaces extended beyond their weekly meets and collective activities. In Chapter four I spoke of how some children had mobilised support groups whom they could rely on in times of need. The friendships built within the youth clubs yielded similar benefits as explained by Pascal.

"The support I have received from my friends in this project is that they do come and assist me without complaining. For example, during weeding time, I called them to come and assist me which they did perfectly. There was also a time when my brother's house fell down and he was away so I called my friends who came and assisted me to mend it." Pascal, 14 (Moja/interview)

Aside from providing the children with a support social space, the longitudinal nature of this project, as well as the intensity of working together for a common purpose, facilitated for some children a trusting environment in which they could build up confidence to freely share their concerns or opinions, which led to a productive sharing of ideas.

“I have learnt many things by working together as a team. Team work is good because people share ideas and you can do something which nobody else thought of. By working together, you gather courage and can talk in front of people.” Carolyne, 15 (Mbili/draw-and-write, see Picture 52)



Picture 52: Draw-and-write picture by Carolyne, age 15

As 14-year-old Pascal explains, for some of the children, participation in the project helped them further their understandings of human dynamics. Previous chapters have highlighted the importance of young carers negotiating social support, illustrating how important it is to facilitate programmes that strengthen their abilities to build supportive social relations.

“Being part of a team is good. It allows people to relate well with other people and teaches you how to live with people in your community.” Pascal, 14 (Moja/essay)

I have previously talked about the knowledge sharing that took place within the youth clubs and many of the above quotations further support this finding. However, some of this knowledge only came about as a result of the supportive social space which the youth clubs provided. Debora gives one example of how this social space, characterised by in-group solidarity and a common purpose, allowed synergies to meet in building local and meaningful knowledge.

“So working as a team is good because it enables me to learn different things. Any challenges we face we can address as a team through discussions and we can come up with good solutions.” Deobra, 15 (Moja/essay)

These supportive social spaces were evident in both Moja and Mbili and partly brought about by the youth clubs, which provided the basic structure for the children to meet, build friendships and work together for a common purpose, and the solidarity and shared circumstances amongst the children.

This created a sense of in-group community, which, as the next section will explore, also helped some children shape their social identities.

7.3.2 Shaping of social identities

In the previous chapter I discussed the importance of social identities in facilitating psychosocial coping. Whilst many of the participating children already drew on local understandings of childhood and a social recognition of their responsibilities to construct a positive carer identity, the youth clubs were found to either reinforce or initiate such meanings and feelings. Fifteen-year-old Michael for example spoke of how his encounter with other young carers in the youth club had provided him with encouragement as he had come to know the importance of being socially recognised for his duties and 'good' behaviour.

"From being part of a team you get knowledge and advice. Our duties and behaviour gets known to other people, further encouraging us to live responsibly." Michael, 15 (Mbili/essay)

For some students, the PLA exercises facilitated a self-reflective process of their circumstances, which helped some of the children ascribe positive meanings to young caregiving. This was the case for Debora, who from her daily diagram exercise and essays, discovered what her caring responsibilities actually mean and can result in.

"I came to learn more on the pie chart exercise where I now know the hours I take to do certain duty in a day. Also the caring exercise would remind me of those that I've cared for. Now I was very happy to write whatever I was doing because by doing that, you get the blessings from God." Debora, 15 (Moja/interview)

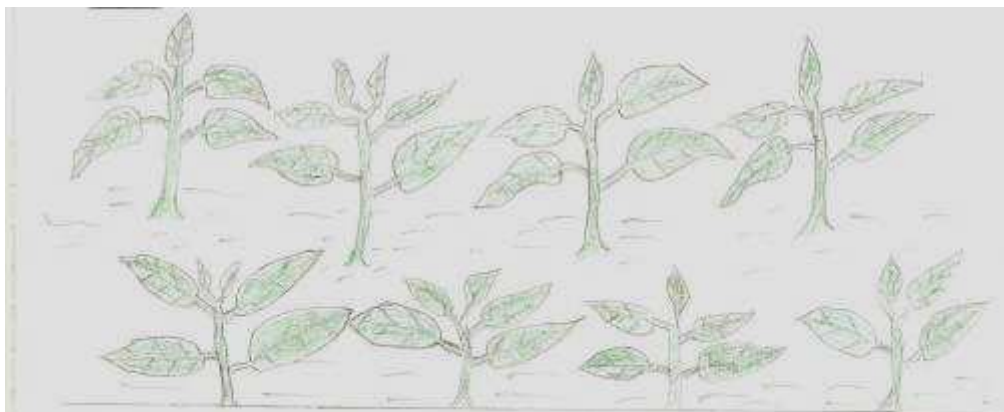
Doing these exercises and spending time with other children in similar circumstances facilitated a sense of in-group behaviour. Through a sharing of stories and circumstances, some children changed their behaviour towards their guardians, conforming and aligning to the in-group behaviour amongst young carers.

"Being with friends has taught me how to respect parents. When he/she tell you to do something, you do it without refusing." Samuel, 13 (Moja/interview)

Although Samuel's strategy to conform might not appear to be a sign of empowerment or progress, it is a decision he made by consciously conforming to what appears to be an exploitative relationship. Similarly, the youth clubs and CCCT activities created a space where gender could be re-negotiated, allowing girls who had previously been inhibited by their gender, to engage in a wider range of coping facilitating activities.

"These activities have also benefited me in that I'm now a hard worker because before I started this project, I could not even work in the farm because it was a hard job but now I have known that there is no gender when it comes to work. I have also learnt that hard work

pays and this have made me to work hard at home.” Jane, 17 (Mbili/draw-and-write, see Picture 53)



Picture 53: Draw-and-write picture by Jane, age 17

This subsection has outlined some of the different ways in which the children’s participation in this project helped them refine and shape a social identity. This underline the impact of bringing together people of shared circumstances.

7.3.3 Agency and awareness of local strengths

One of the more significant findings from the CCCT project is the impact it had on children’s perceived sense of empowerment, self-efficacy and sense of control. These three social psychological resources are important to facilitate when working with children who live in stressful circumstances. This subsection outlines these three social psychological resources and discusses how these are related to agency and awareness of local strengths.

Many of the quotes presented in this section will testify to how their participation increased their awareness and confidence of local strengths as well as their agency. As expressed by 14-year-old Everline: “working together has made me to be strong and active. The ‘working together’ came about through the youth clubs, which allowed a social facilitation process to validate their understandings and local knowledge, making them more confident.

“When children are together, they share ideas, get to know what they were not aware of, a child also develops confidence through team work.” Austine, 14 (Moja/essay)

This confidence came to light when some of the children spoke of how their participation in the programme made them feel more independent from their parents. The skills and confidence they had gained from their hands-on experience made some children realise that they no longer had to rely on their guardians but could manage on their own.

“Since I joined this program I have learnt that I can help myself without asking my parents. This is because I can see that we have our business.” Florance, 14 (Mbili/essay)

Such revelations can be empowering. A number of children articulated very clear links between access to new knowledge and skills, both from their peers and from their experience in implementing CCCT activities, and a perceived sense of empowerment. For some children this sense of empowerment was also observed by their social environment and 12-year-old Kevin provides a powerful example of just how his sense of empowerment unfolded.

“The difference to my life is that before this programme I was unappreciated at home. People undermined me and now after I have earned some money, they started treating me better. You know in the past, if I was to go and beg for something from somebody, I was subject to abuse.” Kevin, 12 (Mbili/interview)

Also a few of the guardians that were interviewed at the end of the project spoke of an apparent change of their children. One guardian perceived her girl as more competent as a result of her participation in the programme.

“My child has shown that she is able to work a piece of land. Yesterday she begged me to give her a goat for her to rear. I now think she is capable.” Female adult15 (Mbili/interview)

The latter quote also highlights the child's improved confidence in engaging with other coping facilitating activities, such as goat rearing, possibly as a result of her friendship with other young carers who rear goats.

This section has demonstrated the way in which the children spoke of the benefits of their participation, suggesting that the CCCT process can facilitate important social psychological resources which can strengthen or give the children access to new coping strategies. The CCCT process was observed to facilitate the construction of safe social spaces that allowed for in-group solidarity and support. Friendships were made, cutting across social (e.g. through sports activities), professional (e.g. implementation of CCCT activities) and private (e.g. home visits and support) capacities. This diverse and longitudinal setting allowed the children to gain coping facilitating knowledge and skills and re-negotiate their social identities. The CCCT experience also permitted the children to build confidence in themselves and their competencies, as well as make them feel empowered.

Whilst many of the children benefitted tremendously from their participation in CCCT, the social psychological benefits presented only tell one side of the story. Some of the emerging themes and quotes presented above might have been produced by children who appreciated the NGO presence and had hope for more support if giving desirable answers. To balance out this one-sided story, the next section will illuminate the limitations and critical accounts that emerged from the data. The children faced a number of difficulties and limitations, both within their groups and as a group in a social context.

7.4 Difficulties and limitations

The data, ranging from investigator field notes to draw-and-write essays and interview transcripts, suggested that the children faced a number of difficulties in implementing their CCCT activities. These difficulties were often a reflection of complex and conflictual local relations evident within their communities. Although the children shared similar circumstances and identities, and belonged to a geographical community, the structure in which they live, work and study is embedded with processes whereby factors such as poverty, adult-child relations, understandings of childhood and other socio-economic inequalities, impact on the children's control, engagement and behaviour within the programme. Layed out as the final organising theme of Table 19, this section explores how some of these processes played out and had a negative impact on the programme.

7.4.1 Power relations as an obstacle

Most of the guardians interviewed for this study were supportive of the children's projects, but they also felt that their involvement was necessary. However, the majority of guardians, viewing the children as competent beings, merely saw their involvement as advisory. One adult usefully pointed out the importance of finding the right balance for adults to provide children with advice and support in order to encourage their continued participation.

"You know they are now grown ups. They are the ones to decide as we advise them. If we decide for them, it might be difficult for them to participate because sometimes they don't like our decision [...] now all we have to do is to support them in their activities." Male adult16 guardian, (Mbili/interview)

Unfortunately, not all guardians thought that way. Unequal power relations, or perceptions thereof, were the cause of a number of difficulties. A few guardians, particularly those from Moja community, did on occasion's abuse their position and took advantage of the programme. They did so in many different ways. One subtle way in which the guardians from Moja compromised the profits made from the children's activities was the discount they gave to friends, or, as illustrated by Pascal, by selling maize on credit, requiring the children to chase up on the 'debtors'.

"Through our programme, some of our parents decided to take some maize to the villages to sell it to community members. These people were not bringing us the money so they gave us a difficult time of walking from one place to another to collect the money." Pascal, 14 (Moja/interview)

A far more serious example of unhelpful parental involvement was that of the theft of the Moja children's profit, money which the children had kept for a re-investment. The guardian to the treasurer stored the money for the group and abused that position to first control the activities and secondly to steal the money and flee to Uganda.

“After that, one of our parents purchased some maize without the group knowing. She sold the maize and when we asked her, she became very cruel. She later gave us Ksh500 each and after that she went to Uganda. From then onwards our programme stopped. She took a total of Ksh 60,000.” Zeddy, 16 (Moja/essay)

The guardian left her daughter (child participating in this study) and only returned from Uganda 8 months later. WVP Kenya staff recently spoke to the guardian who has explained that she went to get alternative AIDS treatment. Whilst there is no justification for stealing, her actions must be understood with an appreciation of her desire to be cured and the poverty she and her family endures. The temptation of having access to such an amount of money could have been minimised had WVP Kenya supported the youth clubs set up group bank accounts. Nevertheless, the children in Moja see a clear link between the theft of their money and their disenfranchised position in society.

“I think what we should do is call a meeting for all people so that we can elect new leaders i.e. Chairperson, Secretary and Treasurer so that we can take away our money from treasurers mother since she does not respect us because we are children and we were told that the business was ours and have power over it.” Austine, 14 (Moja/essay)

As Austine alludes to, committee members were often the ones accused when problems arose. This was partly because of their perceived responsibility to make this programme successful but also their abuse of power. Also the treasurer of Mbili youth club was implicated in accusations of theft. None of the children in Mbili volunteered to keep the profits from their gardening activities in fear of their guardian’s involvement, so they “decided to give the treasurer the money to keep, but at some point when we asked for the money, he told us that he had used the money” (Lucy, age 12). Fourteen-year-old Pascal from Moja attributes many of the difficulties they faced to the committee members whom he claims exploit their position.

“These sometimes happens because seems that they are more powerful than others, and these can be stopped by making all people to be equal but not that other people were the founders of the team, so leaders, members and the chairman of the team should stop being corrupt and be faithful to the team.” Pascal, 14 (Moja/essay)

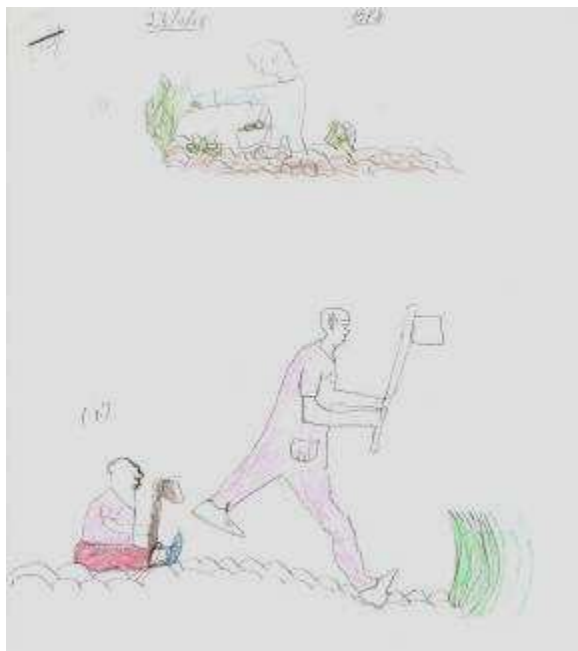
But problems not only lay with the committee members, who as a result of their position, took on significant responsibilities and ownership of the programme. Behavioural differences and poor work ethics also compromised the CCCT activities.

7.4.2 Behavioural differences and work ethics

Idleness and differences in work ethic was one of the most widespread problems articulated by the children. Not all children participating in this programme showed commitment and enthusiasm to participate in the CCCT activities. Possibly because they were not given enough ownership and responsibility, as did the committee members, who showed greater commitment. Those active in

the programme heard many excuses, as explained by John and Michael, by children who did not want to work

“The disadvantage is that while you are working, others are sitting down and not working. Others are pretending to be sick while others are working.” John, 12 (Mbili/draw-and-write, see Picture 54)



Picture 54: Draw-and-write picture by John, age 12

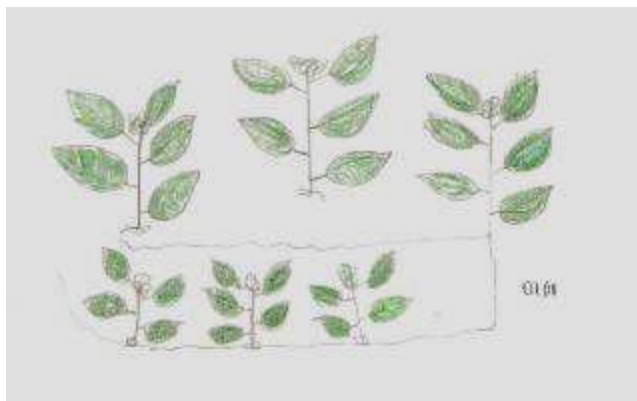
“Some of the team members do come late and rest without working on the garden and this annoys those who came early and worked.” Michael, 15 (Mbili/essay)

As Michael illustrates, the idleness of certain group members was a nuisance to those committed to make the programme worthwhile. For some children, it was not the inactivity by certain members that was a nuisance per se, but the fact their (inactive) involvement would still be rewarded as their idleness was not communicated to WVP Kenya staff. Kevin therefore suggests that those idle should not be rewarded to the same level as those who are active and contribute to the programme.

“People should be straightforward when it comes to work. Also those who are lazy should not be given the same amount as others who are active. I think this can make them work hard.” Kevin, 12 (Mbili/interview)

Besides the idleness of certain members, theft was a frequently occurring theme in their essays and interviews. I have already described some of the more serious cases of theft, but theft was not confined to guardians. In Mbili, some children stole the seedlings from their collective garden, only to plant them in their own garden. Some children, perhaps those who ‘borrowed’ some of the seedlings, blamed the antelopes and others blamed adults from the wider community.

“The problem we faced was that after we had planted vegetables, some people were stealing the vegetables and then they pretend that it is antelope eating them. Some members were also stealing seedlings and then going to transplant in their homes. We then struggled and weed the vegetables then sold them.” Lucy, 12 (Mbili/draw-and-write, see Picture 55)



Picture 55: Draw-and-write picture by Lucy, age 12

As 14-year-old Beryl explains below, these in-group difficulties were a cause of conflict and discouragement. In trying to make sense of these different behaviours, there was some talking behind the backs and accusations being made.

“The difficulties we faced were that some people were not working in the project, which led people to fighting and some were also stealing our things. Why were someone fighting or stealing from the project? The reason why some people were fighting was that sometimes we are making stories and one talk badly about the other. So the person will get annoyed and then they fight.” Beryl, 14 (Mbili/interview)

Exacerbating the limitation of the idleness of certain members and the recurrent stealing from their collective activities was the difficulty in solving these problems internally. Nevertheless, the children showed tremendous problem solving skills to other challenges faced during the implementation of the CCCT activities.

7.4.3 Problem solving

The children actively engaged with problems and were not short in coming up with solutions and recommendations. For example, the children of Moja had forgotten to consider the storage of their maize and negotiated access to the local PO Box centre.

“The problem we faced was that after we had been given the maize, we had nowhere to keep them. We then came together, spoke to some people and arranged a place to store our maize in town.” Samuel, 13 (Moja/interview)

Also the children in Mbili experienced a few problems implementing their activities, but quickly found a solution to those problems. As the farming activities were dependent on a number of external factors, such as pests and weather changes, it was difficult for the children to fully prepare for such events. The children for example, following advice from a guardian, constructed terraces to avoid stagnant water drown their vegetables during the rainy season. Twelve-year-old John also described how they quickly solved the problem of pests attacking their vegetables.

“At some point, our vegetables were attacked by pest which turned the leaves yellow. We were surprised and asked another farmer nearby for advice to prevent the pest from destroying our farm. We were advised to buy ‘easy grow’ which we did and sprayed them. After one week, there was a very big change and our vegetables were very nice.” John, 12 (Mbili/draw-and-write, no drawing available)

As demonstrated in this section, the children faced a number of difficulties and limitations to the success of the programme. These were predominantly related to the power inequalities evident amongst adults and children and between committee members versus non-committee members. The former left the youth clubs susceptible to exploitation by their guardians and the latter left some children uncommitted and idle.

Conclusion

This chapter has introduced the intervention that formed the structure and foundation of this study. The findings presented in chapters four, five and six derive from the children’s accounts and observations made in the CCCT planning stages, observations that facilitated the development of their CCCT action plans. Despite the different action plans, the process of implementation was similar in the two youth clubs and the children therefore benefitted similarly. This chapter has highlighted some of the different ways in which the children benefited from CCCT. The process of mobilising the children to work for a collective cause taught the children about their strengths and the qualities of collective efforts. These include the respect and solidarity that can be generated within a team atmosphere, the knowledge and experience one gains from working with others and how this translates into community development. At a practical level the children gained increased access to monetary resources and school related equipments, addressing some of their more materialistic needs. This not only improved their caring capabilities (e.g. to buy prophylactic drugs), but also gave them an opportunity to escape poverty related stigma by wearing full school uniforms. These practical benefits could have been more significant, had the children not experienced theft from a guardian (Moja) or idleness of certain members (Mbili).

Having said this, the most powerful impact CCCT had on the children were social psychological in nature and relate to the social psychological resources that give content to a social psychology of coping, as described in Chapter two. It is evident from this chapter that the CCCT process enabled the children to access a number of the social psychological resources, including coping facilitating knowledge and skills, supportive social spaces through which a reshaping of young carer identities

took place, and agency and confidence in their own strengths and competencies were developed as a result of feelings of empowerment and control.

Many of the difficulties and limitations experienced by the children were either a result of their disenfranchised position or inexperience in dealing with the poor behaviour of some of their peers. This might suggest that targeting children directly (as opposed to indirectly via their guardians) is inappropriate, as it failed to mobilise and sensitise the wider community. However, considering the many social psychological benefits outlined in this chapter, targeting young carers directly with CCCT (and not their guardians), appears to be one viable intervention to promote their coping and resilience.

The next chapter seeks to discuss the findings presented in this thesis and relate them to the research questions posed in Chapter one and my theoretical framework. In doing so, the forthcoming chapter seeks to explore the implications of the findings presented in chapters four to seven for future policy and practice as well as how these findings can contribute to a social psychological understanding of coping.

Chapter 8 - Children's participation in community life

Introduction and chapter overview

The preceding chapters have explored the lifeworlds of young carers in Western Kenya. Although young caregiving in Africa is not a new phenomenon, it has only recently been subject to investigation, policy and practice. In Chapter one I highlighted the dangers of some of the emerging literature of young carers to frame them as passive victims who suffer from poor mental health and a lost childhood (e.g. Bauman et al., 2006; Bauman & Germann, 2005; Cluver, undated; Donald & Clacherty, 2005; Martin, 2006). In response, I developed some of the critiques presented in the minority literature and presented some alternative views (theoretical and practical) to this dominant representation of young carers. I did this in order to develop a more complex and multifaceted view, reflecting the children's experiences, which would place greater emphasis on coping and positive development.

Whilst I do not dispute the potential for psychosocial distress among young carers or the hardships they face, the aim of this thesis was to provide empirical evidence for a more nuanced and accurate conceptualisation of the role of young carers, acknowledging their agency and competence. In so doing I sought to develop ways of understanding coping as a function of the child's capacity to participate in the life of the community in which s/he is located – all in the interest of understanding how this particular group of children can best be supported to deal with their adverse circumstances and improve their psychosocial well-being.

It was against this background that I in Section 1.6 presented seven research questions that, when empirically investigated, would provide us with important insights and new knowledge into the lives of young carers in Africa. I reiterate these here:

1. What is the nature of their caring roles and responsibilities?
2. What are the psychosocial needs of young carers in Western Kenya?
3. What coping strategies have they developed to deal with their challenging social circumstances?
4. What factors facilitate and/or hinder coping?
5. What is the most feasible way of providing psychosocial support to young carers in Africa?
6. What role can community-based capital cash transfer play in strengthening the ability of orphaned and vulnerable children to cope?
7. How can support agencies best work to reinforce existing and latent coping skills in young carers and their communities?

To guide my empirical explorations in a direction which would address my overarching aim, I presented a theoretical framework in Chapter two. The framework is located within community health psychology and a salutogenic tradition – mirroring my efforts to focus on strengths, existing community support and prevention in facilitating coping, resilience and psychosocial well-being as opposed to the pathology of mental health. To bring forward the neglected community level of analysis in the coping literature, I conceptualised the notion of an orphan competent community (OCC) and presented five initial levels of analysis (appropriate knowledge and life skills, building confidence in local strengths, and agency to mobilise these, economic and political ability to participate in community life, strengthening solidarity and building partnerships and finally supportive social spaces) that can help us understand the role of communities in facilitating or hindering support, levels of analysis which this thesis seeks to confirm and build on. I referred to this community level focus in coping as a social psychology of coping.

The thread running through this thesis has been children's participation in community life. This chapter seeks to synthesise and discuss the empirical findings around this thread and concurrently answer my research questions. This focus will allow me to confirm, adjust or possibly reject the role played by the social psychological resources that make up an OCC in facilitating the coping of orphaned and caregiving children. This final chapter of the thesis finishes with a brief discussion of its strengths and weaknesses and the implications of this study on future research, policy and practice.

8.1 The lifeworlds of young carers

This section seeks to answer the research questions this thesis set out to explore. It will also discuss and contextualise the findings against other empirical reports. In Section 8.1.1 I highlight ways in which my findings, advance, support or contrast existing understandings of the circumstances that characterise the lives of young carers. In Section 8.1.2 I turn to highlight my novel contribution to the concept of coping, discussing the factors that facilitate or hinder coping and examine how this can help us move beyond victimological representations of young carers. Finally, in Section 8.1.3 I round up by looking at how these new understandings can be translated into potential support strategies for young carers.

8.1.1 Advancing our understanding of the needs and circumstances of young carers

As little is known about young caregiving in Africa, it is important to advance our understanding of the needs and circumstances that characterise the lifeworlds of this group of children. In agreement with the existing, but limited research on young carers in Africa (e.g. Evans & Becker, 2009; Robson et al., 2006), this study also found young carers in Kenya to engage in activities that go beyond familial and social expectations of what constitute 'normal' contributions to sustain

household livelihoods. This highlights the relevance and importance of exploring the circumstances that surround young carers.

(i) Caregiving performed by children

Robson and colleagues (2006) have reviewed three studies that synthesise and provide some good initial background to the phenomenon of young caregiving. One of the studies reports on the type of caregiving performed by young people in Lesotho. In agreement with findings presented in this chapter, they reported children to be caring for grandparents, parents, siblings, aunts and uncles (Robson et al., 2006). However, they found children only to be caring for close relatives. This is in contrast to my findings, which found children with strong caregiving identities reporting on their caregiving to a wider sample of elderly or sick community members – highlighting their participation in community life. However, resonating my findings, Robson and colleagues also found children to be sent to live and care for frail or sick relatives, highlighting the key role children play in meeting the needs of illness-affected households and communities (Ansell & Van Blerk, 2004; Young & Ansell, 2003).

In agreement with findings from Lesotho (Robson et al., 2006) and Tanzania (Evans & Becker, 2009), the children participating in this study do both general care (fetch medicines, feed the care recipient and take him or her to the hospital) and more intimate care (massage, apply creams to their bodies, wash, bathe and dress the recipient) as well as domestic chores (fetch water, firewood, pick vegetables, cooking, sweep, washing clothes and dishes) and look after younger siblings. In addition to these responsibilities, my findings show that many children manage not only to provide nursing care for their guardians, but also contribute to the economic survival of their household through subsistence farming and income generating activities (charcoal burning and work for others). This resonates with the findings from Ethiopia (Abebe & Aase, 2007; Abebe & Kjørholt, 2009), Tanzania (Evans & Becker, 2009; Porter, 1996) and South Africa (Donald & Clacherty, 2005). My observation that young carers also play a key role in providing emotional support by listening and providing comfort and encouragement to those sick and old has also recently been observed by Evans and Becker (2009) in Tanzania. They, however, only found a minority of children to provide emotional support (*ibid.*).

Whilst Robson and colleagues (2006) found girls in Lesotho to engage in more caring than boys, thus confirming what is already known about gender relations (Butler, 1999; Navaie-Waliser, Spriggs, & Feldman, 2002), the situation was not so clear-cut in Kenya. Although slightly more girls reported doing nursing/cleaning responsibilities and slightly more boys reported doing income generating activities and tethering animals, only few households could afford to live up to local gender roles. This is in agreement with recent findings in Tanzania, where Evans and Becker (2009) found no significant differences between the household chores that boys and girls did. This not only reflects a re-shuffling of resources within the household according to circumstances (cycling of resources), but also a strategy to socialise boys to do such duties in preparation for the possible premature death of their own spouse one day. In fact, children's engagement with previously gendered duties may serve to prepare them for a future where rigid gender roles may be

detrimental to their coping. Also Ruiz-Casares (2007) in her study of child-headed households in Namibia, found the lack of social resources evident within many such households to leave gender roles increasingly fluid. This indicates how the AIDS epidemic can change local understandings of childhood and the socialisation of children (Kesby et al., 2006).

The review paper by Robson and colleagues (2006) found young caregiving to be a temporary affair. This observation is in stark contrast to the findings presented in this thesis, which suggest that one caregiving experience often leads to another. Aside from the sheer need of many households and the different ecological contexts that shape their circumstances, this thesis found 'caregiver identities' to play an important role in encouraging continued caregiving. These identities were shaped by children's social environments. For some children, caregiving continued because some adults automatically encouraged children with previous caregiver experience to care for others – seeing them as (experienced) caregivers. On other occasions, some children had constructed positive carer identities, focusing on the benefits of being a caregiver, and therefore willingly chose to continue as 'helpers'. This is in contrast to observations made by Evans and Becker (2009:165) who found that "most young people did not identify themselves as a 'carer'."

As I investigated the factors causing recurrent caring experiences, the pattern that emerged reflected a 'continuum of caregiving', which is illustrated in Figure 11 (page 162). In this continuum, many children move in a natural order, caring first for siblings (a natural thing for children to do in this context), then their ailing parents, followed by their ageing grandparents and eventually their (ailing or ageing) guardians (often aunts or uncles). I located the continuum within an ecological context to highlight the many factors that influence the nature of their caregiving experiences – including who they care for, what duties they engage in and the social resources available to them – and to underline that this continuum is fluid and by no means representative of all children. It must be understood within a context. This study therefore suggests that children's experiences of AIDS can be long-term and cumulative, echoing an observation also made in South Africa (Hosegood, Preston-Whyte, Busza, Moitse, & Timaeus, 2007).

(ii) Reciprocity of Care

A core theme running through the findings presented in this study is that of reciprocity of care. In a context of AIDS, poverty and the absence of old-age pension schemes and social security, young carers in Kenya contribute significantly to the welfare of the elderly and the sick. They do so for a number of reasons, some of which were mentioned above, including cultural expectations and sheer need, but also out of mutual love and respect. Whilst both Robson and colleagues (2006) and Evans and Becker (2009) have highlighted the reciprocity of support that characterise the relations between some children and care recipients, nobody has yet outlined how and under what circumstances such relationships are constructed and how this can encourage young caregiving.

Whilst cultural expectations and need are indeed important factors, the notion of 'reciprocity of care' proved to be of utmost importance. In a context of AIDS and mortality, many of the children participating in this study reported a tremendous sense of gratitude for being under the 'care' of an

adult. The children felt it was important for them to receive guidance from adults and to be under the guardianship of adults. Through this guardianship, the children could get disciplined, receive advice and have access to important social resources. This was particularly the case of children who had nowhere else to go, or did not know where to go when their parents or current guardians died. Their gratitude for this type of 'care' was reflected in the respect, love, empathy, hard work and 'care for' that characterised their relationship with their guardian. Although the type of support guardians and children gave each other was different, it highlights the reciprocity of care and support evident within many such households.

What transpired from my analysis is that local understandings of childhood and caregiving do matter in this debate and that many children in this context actively draw on these understandings during or before embarking on caregiving. There is a social recognition of children who provide care and support for ailing and ageing guardians. Such children conform to, and exceed, local expectations of childhood as a period of duty and service, and therefore earn the respect and receive blessings from adults in their communities – proving to be a social psychological resource that encourages young caregiving. Moreover, this social recognition of their responsibilities enables the children to ascribe positive meanings to their circumstances, including a focus on all the benefits to young caregiving. Their acknowledgement of personal growth, emotional maturity, learning of new skills and development of reciprocal relationships all played a role in the children's decision to provide care and support for adults.

These findings challenge dominant representations of young carers as passive victims and burdensome, highlighting the reciprocity, and sometimes reversal, of care and support responsibilities in the child-caregiver relationship. This suggests that the commonly used term 'caregiver' may not always best represent the role of a foster parent, due to its simplistic representation of adults as the givers and children as the receivers of care. I therefore suggest that 'guardian' serves as a more neutral and appropriate term to describe the role of foster parents, and one which better reflects the reality of the reciprocity of care and support evident in many fostering households.

(iii) Challenges faced by young carers

This thesis has brought forward some of the many challenges faced by young carers in their day-to-day lives. Young caregiving is by no means an easy job. The children participating in this study reported on challenges related to poverty, their psychosocial functioning, and managing both school and caregiving.

Poverty was experienced through inadequate access to nutritious foods, difficulties paying for school related costs and their relative deprivation of basic materials (such as shoes and beds) compared to non-caring children. Many of the children also lived in poor housing, with broken thatched roofs making it difficult for the children to study when rain and wind entered their huts. Whilst these challenges were not distinct to young carers, they do characterise the deprivation in which many of them live. More distinctive to young carers were their psychosocial challenges.

These psychosocial challenges included a lack of social support, experiencing parental bereavement and the sadness that follows such experiences, being worried about what the future might bring and feelings of fear. A few children also reported being bullied by other children and abused and neglected by adults, often as a result of the stigma attached to HIV/AIDS. These observations are only slightly different from those made by Robson and colleagues (2006:105) who found that their hardship came from “deep personal sadness at the loss of a grandparent, parent or other close relative, as well as grief and possibly feelings of regret or guilt.” Evans and Becker (2009), who focused on children caring for parents with HIV/AIDS, found stigma to be a significant contributor to children’s social isolation and lack of social support.

Whilst some children without doubt had feelings of grief and sadness following the death of a loved one, there were also a couple of occasions where there was a sense of relief following the death of a parent. However, such feelings were only prevalent in households with very limited social support and where the child was really struggling making all ends meet. A more prominent finding of this study was the worry many children had for the well-being of their care recipient. Some children reported on their worry of losing their parent or guardian (care recipient) and how this worry interfered with their concentration in school and sleep. This coupled with the fear of what would happen to them following the death of their remaining parent (e.g. staying with an abusive step mother or being sent to stay with relatives in another district, away from friends), is likely to have an impact on the psychosocial well-being of some children.

Whilst grief counselling could benefit a minority of children, a social psychological style of counselling, such as peer counselling and support, could help these children overcome some of the psychosocial challenges described above. A recent study by Kumakech et al. (2009) looked at a social psychological intervention for AIDS orphans in Uganda. The intervention involved 16 psychosocial sessions with trained teachers and a professional counsellor in a school setting. The intervention found that peer-group support decreases the psychosocial distress experienced by some orphaned children, particularly when it comes to levels of depression or feelings of anger. The positive impact of peer counselling and support on people affected by AIDS has also been documented in the Netherlands (Mulder et al., 1994) and China (Molassiotis et al., 2002). Whilst the CCCT initiative explored in this thesis provides children in difficult circumstances with the financial and social psychological resources to cope with adversity, there was no formal focus on peer counselling. Although the youth clubs most definitely provided a safe space for the children to share their problems and concerns, this informal set-up could have benefited from more structured peer counselling sessions – helping the children overcome some of their psychosocial challenges. This is an important area that requires further research and exploration.

I have briefly mentioned the impact feelings of worry can have on the children’s education. This matters because education is hugely important to the children, often perceived as their only chance out of poverty, and it gives them a good break from duties and time to be with peers. Two of the studies reported on by Robson and colleagues (2006) derived different findings with regards to the

impact of caregiving on education. In Tanzania, young carers were found to have irregular school attendance whereas in Zimbabwe they found the majority of young carers to drop out of school. The study I report on here found the impact of caregiving on their education to be determined by the amount and type of social support available to the children. Some children therefore had irregular school attendance whilst others had little choice but to drop out of school for various lengths of time. What is certain is that caregiving does in many cases negatively impact their school attendance. However, whilst one might assume this also has a negative impact on their school performance, this thesis found a number of children to bounce back and even improve their school performance rank. This might be an indicator of the resilience many children are able to develop. A similar observation has been made by Evans and Becker (2009) who found that over a third of the participating young carers in Tanzania did not think that their parent's illness or caregiving had any significant impact on their school attendance and performance. Dropping out of school for a year to provide care for ailing or ageing guardians, does not have to be detrimental to the child's school performance in the long-term. Although caregiving may come with a high cost at one point in time, their perceived disadvantage may encourage this group of children to work harder and with more commitment to do well in school. The ability of orphaned children to stay in school and continue to do as well, or occasionally better, than their peers has been observed elsewhere in Africa (Bennel, 2005; Pagnier et al., 2008; Parikh et al., 2007).

This study has advanced our understanding of the circumstances and needs of young carers by supporting findings of earlier studies in a Kenyan context, contrasting other findings, and adding nuances to other studies already reported on elsewhere. I now move to discuss the novel contribution of this to our understanding of how young carers cope with difficult circumstances.

8.1.2 The coping strategies of young carers

In this subsection I will reflect on the findings and discuss the coping strategies the children had developed to deal with their challenging social circumstances as well as the factors that were observed to facilitate and/or hinder coping and relate this to support strategies. Their coping strategies fall under three categories; (i) accessing and mobilising social support, (ii) engaging in income generating activities and (iii) constructing positive identities – each of which will be discussed in turn.

(i) Accessing and mobilising social support

The children participating in this study had access to different levels of social support. A primary source of social support was the immediate and extended family. Male relatives often contributed with money and female relatives more often visited the households and supported them with food and nursing care. It was often the oldest child living at home who took the role of head of household responsibilities. This meant that if the first born child had moved away from home and begun working, he or she could continue supporting the siblings staying at home by sending back money or food. However, not all young carers had an older sibling who could send money and they relied more heavily on the support of extended family. Whilst many children did benefit from their

extended family, the stigma associated with AIDS sometimes impeded this support, an observation also made by Evans and Becker (2009). Although family support came more easily than other types of support, the children often had to ask for support or remind relatives of their circumstances.

Support from community members and groups also remain critical to coping. As an addition to the sometimes limited support from family members, the children could negotiate support from community members and neighbours, who often acknowledged the difficulties of caregiving children, helping them to buy drugs for their parents, school materials, clothes and food. While some children accessed food and support from neighbours easily, the majority of children had to actively negotiate this level of support using various strategies. One such reported strategy was to help community members or neighbours with their harvest and in exchange the child could use parts of their land for their own crops or simply get some of the harvested corn. Looking poor and conforming to stereotypes of vulnerable children in this context was also a strategy used by some children to negotiate support from community members and neighbours.

Much of the support from community members was channelled through various grassroots groups, typically established by widows to support orphaned and caregiving children by providing them with meals. Community and grassroots groups fill the social landscape in Bondo and this study has verified the importance of such a social space in helping children and other vulnerable community members. Nevertheless, community support was not available to all the children and could be constrained by additional challenges such as drought.

In addition to many adult-run grassroots groups, some children were able to run groups and clubs aimed at helping one another with practical and emotional support in times of need. All the children mentioned friendship as a great sources of support and help, suggesting that children themselves are able to mobilise very effective and supportive friendship groups and networks with other orphaned and vulnerable children, a capacity also identified by Donald and Clacherty (2005) in South Africa. Although Evans and Becker (2009) also found young carers in Tanzania to enjoy spending time with friends, they, in contrast to my findings, found that young people very rarely asked for help and practical support from their friends.

Having supportive friends in times of hardship was identified as an important psychological support mechanism. School was named as a source of many support friendships. In addition, school was also identified as a place of hope, helping children to believe in themselves and to construct hopeful representations of their futures. Although there were a minority of exceptions where schools and some teachers were described as judgemental and excluding, schools often acknowledged the challenges faced by many caring children and teachers showed them flexibility and support. A supportive school environment has previously been identified as important for building the resilience of children in difficult circumstances (Gilligan, 2000; Schoon, 2006).

Churches and their members were also mentioned by many children as sources of food and emotional support. The role of faith in helping the children cope was noteworthy. Many children

believed that “God gives answers and is always there” for them. Furthermore, the children often saw themselves as receiving blessings from God as a result of their efforts.

This subsection has illustrated some of the ways in which young carers actively mobilised resources from their social environment in coping with difficult circumstances. However, echoing findings from Rwanda (Thurman et al., 2008) and Tanzania (Evans & Becker, 2009), it is evident from this study that poverty and AIDS stigma may limit the availability of social support. Nevertheless, only a minority of children did not manage to mobilise supportive social resources, especially in times of drought in highly stigmatised homesteads. It was when such social resources were limited that the children actively and competently engaged in income generating activities that helped sustain their livelihoods.

(ii) Engaging in income generating activities

Whilst caring roles and responsibilities differed according to the circumstances of each household, all the children in this study contributed significantly to wider household subsistence efforts. This was generally as part of a collective effort, with only a few doing this single-handedly. They did so by engaging in various income generating and farming activities.

Most children reported on the importance of animals in generating food and income, which helped them with school-related costs and to diversify their diet. It also enabled them to purchase medicines and provide nutritious food for their ailing guardians. Cows, goats and chickens were also found to give the children hope for a brighter future with offspring serving as an insurance and growing asset.

As this study took place in a rural area, the ‘shamba’ (garden, piece of land used for farming) played an important role for all the children in this study. The shamba enabled children to grow vegetables and in some cases, mature fruit trees enabled them to raise money through selling fruit at the nearby market centre. Almost all the children spoke of the importance of fruit trees and vegetables in generating income. In doing so, the children had to make decisions on what to grow in their gardens, how to optimise productivity, when produce was ready to be sold and at what price.

Although gender only played a small role in duties carried out at home, income generating activities conducted in more public spaces were highly gendered. Many boys burned charcoal to sell at the nearest market centre. Girls offered domestic services to more affluent community members, including laundry and gardening for small payments.

The involvement of all study participants in some form of income generation – ranging from animal keeping to subsistence farming and charcoal burning – testified to their competence, active social engagement and decision-making skills. The extent and time spent on these activities appeared to differ according to the availability of social resources.

(iii) Constructing positive identities

Nearly all the children in the study were able to depict their role as caregivers in some positive light. This is in agreement with findings from Zimbabwe and Tanzania, where young carers reported on the benefits of providing care as well as the costs (Evans & Becker, 2009; Robson et al., 2006). Caring was regarded by many children as the facilitator of valued personal growth. Children referred to caring as a source of skills and independence which would stand them in good stead throughout their lives. Practical skills gained from caring included caring and nursing skills, income generation and personal qualities including empathy, commitment and being a hard worker. This study has not only confirmed some of the many positive meanings young carers ascribe to their personal growth and emotional maturity, but has also explored some of the underlying causes for these positive meanings.

The meanings ascribed by the children reflect who they are and may therefore be influenced by their identity and self-perception. Their self-perception or identity is negotiated with their social environment and it is to this end I found local cultural understandings of caregiving and childhood to serve as useful symbolic resources in constructing positive carer identities. With a local perception of a 'good' child as being helpful in the home, caregiving children were by implication of their duties exceptionally good children, feeding a social recognition of their responsibilities. This allowed many children to view caring as a challenge and opportunity for personal growth and a socially valued service, rather than a hindrance or obstacle in their lives. As a result of such notions, some children went to the extent of identifying themselves as 'helpers', having strong caregiver identities, whilst others drew on this social recognition more moderately, yet were still able to identify the benefits of young caregiving.

Whilst a minority of children ascribed either entirely positive or entirely negative meanings to their caregiving experiences, most of them attached mixed meanings, reflecting a continuum of caregiver identities. Negative meanings were often fuelled by a lack of social support and poverty. However, older children who were conscious of the possible long-term impacts of their disrupted school attendance, were found to derive less comfort from cultural representations of a 'good child' than their younger counterparts, viewing their interrupted education in a more negative light. The long-term impact of caring on education and school attendance was the greatest concern for many children. Their regret at their interrupted education was at the root of almost all the negative meanings informants ascribed to their caregiving roles.

Nevertheless, many children in this study drew on existing local representations of childhood, as a time of duty and service, to create a positive carer identity. The meaning given to life circumstances, and the social representations (e.g. of childhood) that inform the construction of meaning, play a key role in shaping how individuals cope with adversity (Barkwell, 1991; Lipowski, 1970). Woodhead (1998) has previously identified the active role working children play in giving meaning to difficult circumstances in order to make the best out of their situation.

As I framed this study within wider debates about the processes of coping and resilience, and the view of children as competent social actors, I have illustrated how many children in this study managed to cope with the challenges of caring for ailing adults in challenging conditions. This subsection has highlighted the skills shown by many children in mobilising social support, engaging in income generating activities and constructing positive identities, supporting my reservations about the tendency of some researchers to view young caregiving solely as a source of risk and adversity. I have also drawn attention to the way many children regard their caregiving experiences as a source of growth and personal development, providing them with valuable life skills.

8.1.3 Developing support strategies *with* young carers

The preceding subsections have synthesised the factors that impact on the children's caregiving experiences as well as some of the ways in which many young carers have actively constructed effective coping strategies. It is their active participation in community life, as children, caregivers, producers and entrepreneurs, to navigate and negotiate support and positive identities from their social environment, which makes it appropriate to view many of them as competent social actors taking charge of their psychosocial well-being.

I believe that service delivery organisations should not only take heed of these findings in shaping their policies and services so as to identify, acknowledge and work with children's existing and latent coping strategies and the role they play in the community, but actively draw on their agency to strengthen their psychosocial well-being and skills base through participation. Speaking with service providers in Tanzania, Evans and Becker (2009:216) noted the view that "building young people's lifeskills through vocational training and providing capital to start small businesses could help to promote young people's resilience." One way to do so would be to mobilise and provide groups of young carers (or community organisations) with the resources required for them to cope and strengthen locally appropriate support strategies. This is what I did in this study by implementing a CCCT programme to support young carers with the facilitation of WVP Kenya, a local NGO.

Rather than working with adults in the community and support their efforts in helping caregiving children, I decided to report on an intervention which sought to work directly with the children in partnership with staff from WVP Kenya. Staff from the NGO approached the children as active agents and social actors and set out to facilitate a five-step project cycle *with* the children. The children were first provided with the tools and the space to adequately reflect upon their circumstances (step 1). They were then guided to develop action plans (step 2) and trained according to the activities they set out to implement (step 3). The Moja youth club decided to implement maize selling whereas the Mbili youth club bought new school uniforms and commenced on poultry keeping and kale farming (step 4). Facilitated by research tools, the children observed their progress (step 5) and were encouraged to come up with recommendations for improvement.

The participatory nature of this project mobilised the children to work for a collective cause and taught them about their strengths and the qualities of collective efforts. These included the respect and solidarity that can be generated within a team atmosphere and the knowledge and experience they gained from working with others. This in turn led to the construction of supportive social spaces where young carer identities could be renegotiated and where agency and confidence in their own strengths and competencies could develop further. These social psychological resources were a result of the children's participation in the CCCT process. Whilst the project was successful in facilitating resilience and strengthening existing coping strategies, the practical outcomes, often the primary concern of NGOs, were somewhat disappointing. The children gained access to significant monetary resources to address some of their more materialistic needs (as well as to develop the above social psychological resources). However, I believe the children did not benefit optimally from the programme, primarily as a result of the many challenges the children faced. These included retention, the inappropriate involvement of parents and theft by both adults and children.

Many of these difficulties and limitations might be indicative of the children's disenfranchised position in their context and their inexperience in dealing with the poor behaviour of certain peers. It could be argued that targeting children directly (as opposed to indirectly via their guardians) is inappropriate, not only because of the likelihood of them experiencing challenges related to their disenfranchised position in society, but also because the project actively encouraged children to work. There is a strong social movement against child labour and children's work (cf. Haspels, Jankanish, & International Labour Organisation., 2000; Shandilya, 2003). Although I welcome efforts to eliminate certain forms of child labour, there are levels of informal children's work that are locally important and relevant. Whilst head-of-household responsibilities and child caregiving may just be on the boundary of what many people would deem acceptable, structural and financial limitations leave no other alternatives. This is well articulated by the Children's Officer of Bondo District, who is repeatedly confronted with situations where he ought to react, but the local context and structural limitations give him little choice but to ignore what he observes.

"If there is a child who is working in the beach, fishing for someone, he is being paid; you may call it child labour. The child has a bedridden mother at home, the Children's Department goes to the beach and finds the boy working, he is under-age and they want to take action and they go to the home and they see the mother is bedridden, what action can they take? Nothing."

Whilst CCCT has got many qualities, such as facilitating ownership of community-based responses, some children may be too busy with their caregiving duties and income generating activities that they cannot find the time to participate in community-based activities. Some of the drop-outs experienced in this particular intervention can be attributed to such circumstances. As a result, stipend and household based cash transfers might help children like the boy described by the Children's Officer and some of the children that had to drop out of our CCCT project. It is therefore recommendable to implement CCCT and stipend and household based cash transfer schemes

alongside each other, simultaneously using the community structure to identify OVC and disperse the money as well as reaching the most vulnerable orphaned and caregiving children (Evans, 2008).

Considering the many social psychological benefits outlined in this thesis, targeting young carers directly with CCCT (and not their guardians), does appear to be a viable intervention to promote their coping and resilience. Having said this, I would not encourage youth clubs of the size and spread used in this study. Having learnt from this project, WVP Kenya is currently implementing CCCT with young carers in groups of five (effectively group-based capital cash transfers). These five children know each other, live in close proximity and will as a group follow the same participatory project cycle and set up coping facilitating activities.

This section has synthesised and discussed the empirical findings of this research project. It has confirmed and contrasted certain findings and presented new information that helps us better understand the circumstances that characterise young carers in an African context. I drew on these findings to develop an intervention, the first intervention believed to specifically target young carers as social actors, and not as children solely in need of grief therapy, and shared lessons learnt from this experience. The next section will pick up on these empirical findings and situate them within my theoretical framework and contribution.

8.2 Towards a Social Psychology of Coping

In my attempt to move away from theories of coping that focus on the individual, and seek to generate universal and generalisable conceptualisations of coping processes, I was guided by more recent research which shows that coping will always be a context-specific activity and shaped by the particular problem that a child faces, and enabled or limited by the social, political and economic situation in which he or she is located (Ungar, 2008). Ungar sees children's resilience as the outcome of a process of active negotiation between individuals and their social environments – an understanding which opens up for an exploration of the individual-community interface. Panter-Brick (2002), in a context of street children, has also observed coping as a reflection of children's agency and engagement with their social environment and not only the availability of protective factors. It was against this background that I set out to work towards a social psychology of coping, a conceptualisation of coping which assumed children were active co-constructors of their social worlds and which gave me the framework to map out the way in which young carers engage with what Rutter (1979) refers to as 'protective factors' (e.g. social support, household cohesion, personal attributes) within their communities.

In this thesis I have documented and outlined some of the processes in which young carers actively negotiate with their social environment, drawing on local understandings of childhood and caregiving, to help them cope with difficult circumstances. I identified at least three particular ways in which the children participating in this study coped. They did so by (i) actively contributing to household survival – engaging in income generating activities, helping to nurse sick or disabled

guardians or other family members, (ii) accessing and mobilising support from their social environment and (iii) constructing positive identities.

As a result, a community-level focus on coping not only highlights children's role as contributors to social life, and their ability to act upon this role, but also the level of support available from their communities, both practically (e.g. social cohesion and solidarity) and symbolically (e.g. local representations of childhood helping young carers to construct positive identities). Against these findings, I can conclude that the extent to which a child is able to cope depends on:

- i. the on-going negotiation between individual and community which shapes a person's identity and access to local support networks and resources to tackle adversity
- ii. the quality of the community that they live in and its ability to share resources
- iii. children's different abilities to negotiate community support and actively engage in activities that sustain their livelihoods.

Children's coping strategies are effectively determined by the extent to which they are able to participate in community life and negotiate support from it. I believe that this social psychological understanding of coping opens up for a whole new level of analysis, a level that explores community-based activities and the impact of community relations on the coping of individuals. As the community plays a crucial role in enabling or hindering children's chances of coping with difficult circumstances, it is vital that we target and support communities in their efforts to support vulnerable children. As the children's participation, and effectively coping, is dependent on their context and quality of community, I highlighted five social psychological resources in Chapter two that could hinder or support their coping. I referred to these social psychological resources as the ingredients for an orphan competent community. The next section will reflect upon my empirical findings and finalise my proposed conceptualisation of an orphan competent community.

8.2.1 Orphan competent community

In Section 2.3 I presented the social psychological resources that Campbell and colleagues have identified to be important in facilitating community efforts in the care and support of people affected by AIDS. I adopted those dimensions of an 'AIDS competent community' (Campbell et al., 2007; Campbell et al., in press) that I felt were relevant to the coping of orphaned and caregiving children – with the aim of conceptualising the notion of an 'orphan competent community'. Based on my review of coping, resilience and social psychology in Chapter two, I conceptualised an OCC as one in which orphaned and caregiving children and their fostering households are best able to successfully negotiate and access support from their social environments (including neighbours, self-help and volunteer groups, church groups, schools, NGO and government welfare services). I believe that the findings presented in the preceding chapters fully support this definition. I also believe that the five-point conceptualisation presented in Chapter two is suitable to my observations in Kenya, albeit with one important social psychological resource missing – that of the symbolic

resources used to build positive social identities. My concluding conceptualisation of an orphan competent community therefore has six social psychological resources:

- i. Appropriate knowledge and life skills
- ii. Awareness of local strengths and agency
- iii. Economic and political ability to participate
- iv. Strengthening solidarity and connectedness
- v. Supportive social spaces
- vi. Positive social identities

Drawing on my findings, I will briefly synthesise what I refer to in each of these resources, and include any modifications to my earlier theoretical discussion of these building blocks. Although I primarily draw on lessons learnt from the youth groups, I refer to the community as a whole in my conceptualisation, making it transferable to other locations.

(i) Knowledge and Skills

Residents of OCCs should acknowledge the magnitude of the impact of the HIV/AIDS epidemic and have good factual information about the disease and its impact on children. Residents should also have a sound understanding and awareness of the children's coping strategies and community responses to orphan care and support. Community members should therefore be able to identify and pass on knowledge and skills that can be used by children to facilitate their coping (e.g. community members teaching vulnerable children how to make charcoal). This process involves an appreciation of children's active participation, traditional support strategies and existing community services (such as community health workers and barefoot paralegals). In order to provide good quality care and support, residents should have the skills and confidence to adequately 'translate' and draw on these practices in their support of orphaned and caregiving children (discussed below).

(ii) Awareness of local strengths

It is important for children and community members to be aware of their own assets and local strengths as well as have confidence in using these. This allows them to competently engage in activities that might support them in their efforts to sustain vulnerable households. It is also important for community members to have confidence in their collective ability to support orphaned children with, for example, food and education via community initiatives (such as communal gardens cultivated by community members to generate food for orphaned and caregiving children or orphan day care activities to educate the youngest and non-school going orphans) and their individual efforts to make a difference to the lives of orphaned children. If individuals are confident in their local strengths, they are more likely to become involved in decisions that affect the lives of orphaned and caregiving children. Agency and confidence of community initiatives cannot be taught, but must be facilitated through practical experience (Cornish, 2006) – such as CCCT initiatives.

(iii) Economic and political ability to participate

In a context of poverty it is not enough to train people and encourage them to draw on existing coping strategies and community responses. Local responses are increasingly stretched to the limit and need to be supported with material and social resources. It is therefore vital for communities to have the capacity to build supportive partnerships with local and extra-local community groups and organisations that can facilitate them, with economic contributions, in supporting OVC. Reflecting the partnership with WVP Kenya, it is beneficial for a marginalised community to work in partnership with agencies and individuals who have the political and economic power to facilitate effective local community responses. Such alliances can generate resources that poor communities would otherwise not have access to (Campbell, 2003). This type of 'bridging' social capital has previously been identified as a precondition for effective community responses to AIDS (Gillies, 1998; Szreter & Woolcock, 2004). Having said that, material and social resources should not be passed on to the communities without them taking ownership and responsibility of the challenges posed by growing numbers of AIDS affected children. Communities need to view themselves as having an active role to play in tackling this problem, rather than waiting passively for government or NGOs to come and solve the problem. PLA tools, as exemplified in this study, are useful in facilitating ownership and participation.

(iv) Solidarity and connectedness

Communities that are characterised by sympathetic and supportive relationships provide the optimal context in which children and households affected by AIDS can negotiate support from members within the community, including access to much needed resources such as land for cultivation, livestock, food, money covering for school related costs and empathy more generally. This is commonly seen amongst neighbours' support of vulnerable households or supportive friendship groups amongst children. Although the youth clubs represented a community of shared circumstances, there were still varying degrees of co-operation and conflict, with children having different interests and agendas. Similar observations have been made in geographical communities (Cornish & Ghosh, 2007). In an OCC, solidarity and connectedness allow people to support each other despite their differences and work for a common purpose. Relationships of solidarity also provide favourable conditions for supportive social spaces to emerge.

(v) Supportive Social Spaces

Orphaned and caregiving children need supportive and sympathetic social spaces in which they can more easily negotiate support and discuss issues that affect them. These social spaces allow community members to brainstorm/explore ways in which orphaned and caregiving children are best supported, and the types of support they might need to best do so. In many SSA settings, as in Bondo, local community organisations and initiatives have sprung up in response to the increasing number of children affected by AIDS. Grassroot groups, schools and church groups are fundamental to creating supportive social spaces for orphaned and caregiving children in a rural SSA setting. Supportive social spaces can be facilitated and strengthened through initiatives such as Stepping Stones (Welbourn, 1995), Community Conversations (UNDP, 2004) and PLA tools (Rifkin & Pridmore, 2001). In supportive and safe social spaces, children are more likely to refine

and develop a social identity. This was evident from the youth clubs described in this study. Likewise, community members are more likely to change their attitudes and behaviours towards the support of orphaned and caregiving children if they see that liked and respected people within their communities take this issue seriously.

(vi) Social Identities

Social identities arise from membership of an 'in-group' or a community and our need to locate ourselves in the environment in which we live, evolving from our desire to stand out and belong to particular social groups (Howarth, 2001, 2002). Social identities can also be imposed and instead of being members of an in-group, one can become a member of an out-group (Marková, 2007). Orphaned and caregiving children may therefore see themselves a distinct group of children (in-group) or be alienated by school friends due to stigma of the disease causing their parents to be bedridden (out-group) – processes that can both hinder and facilitate coping.

In this study, local understandings of childhood helped children give meaning and sense to the circumstances that surround their difficult circumstances. Duveen (2000) has explored the impact of social representations on identity construction. He argues that children draw on social representations available within their community to learn to see themselves as others do. The children in this study drew on the social representations of childhood to understand what was normally expected of children and create a social identity that reflects this understanding. If care and support of adults by children is a virtue and a sign of good upbringing, then young carers are in a good position to draw on this representation to create a positive social identity that helps them make sense of their circumstances and effectively cope. Nevertheless, as much as representations of childhood can be used to create a positive identity, they also play a key role in the process whereby unequal power relations are reproduced (Campbell, 2003). For example, representations of childhood may reinforce the didactic relationship between adults and children, promoting a 'culture of silence' amongst children who are unable to voice any resistance due to age-driven inequalities. However, the same representations that may devalue an identity at one level may promote a positive sense-of-self at another. For example, young carers who live up to many of the cultural expectations of a working child may well draw on these representations to construct a positive identity. The process through which people derive meaning to their circumstances may therefore involve the negotiation of identities – all of which facilitate coping.

Building orphan competent communities

I believe that the six social psychological resources highlighted above constitute pathways through which communities can best offer optimal support to AIDS-affected children in ways that reinforce children's resilience and coping and which build on the actual and latent strengths and resources that exist, even in resource-poor communities. Echoing the intervention described in this study I believe these social psychological resources are best facilitated through participatory processes.

While the facilitation of OCC should involve both adults and children within a community, I explored the impact of a CCCT initiative at a micro-level and with the participating children only. By doing this

I involved the children in a participatory action research process and concurrently explored the role of participatory processes in facilitating the social psychological building blocks described above.

I believe that this conceptualisation and the background provided to the intervention, provides a useful framework for analysing the contexts in which orphan care and support programmes are located in the interest of formulating locally appropriate intervention strategies and local responses. Although this conceptualisation of OCCs provides a useful framework for analysis and action, my experience of working with these children is that it is the process in which the communities (or groups) are facilitated to strengthen the social psychological resources of an OCC that is of utmost importance. It is evident from the findings presented in Chapter seven that WVP Kenya played a critical role in implementing the projects. The experience and attitude of staff and other professionals setting out to facilitate OCCs is therefore an equally important element to this process.

I hope that the findings presented in this thesis, and my conceptualisation of an OCC, have highlighted the usefulness of a social psychological understanding of coping. I also hope that my observations, influenced by a social psychological understanding of coping, will encourage others, albeit in different contexts, to investigate the coping strategies determined by the individual-community interface.

8.3 Public accountability and limitations

As is the case with all exploratory research studies, care needs to be taken in accepting the trends and relationships outlined in this thesis, particularly due to the small sample size and the specific location of the study. Doing research *with* children, as opposed to *on* children, requires the researcher to move beyond already established 'good practices' of qualitative research (Christensen & James, 2000). The methodology used in this study may therefore appear unconventional or innovative depending on whom you ask. To assist public scrutiny of my claims and warrants, this section seeks to provide a reflexive account of the study and my writing process.

8.3.1 Quality criteria

According to Bauer and Gaskell (2000), criteria of reliability and validity are inappropriate tools for assessing small, context-dependent qualitative studies of the kind I have done. They argue for an alternative set of criteria for assessing the rigour of such research, namely triangulation and reflexivity, transparency and procedural clarity, corpus construction, thick description, surprise elements and communicative validation. Each of these six criteria is now discussed in turn.

The first of these criteria relates to triangulation and reflexivity. Whilst my multi-method approach allowed me to triangulate meanings that arose from the data, this also gave rise to numerous contradictions and inconsistencies. One girl for example ascribed very positive meanings to her caregiving in an essay, whilst in an interview she ascribed primarily negative meanings. For me to

make sense of such inconsistencies has been challenging. Are these differences just a matter of cognitive polyphasia (cf. Marková, 2003), the existence of different understandings for a single phenomenon, and were the differences in meaning communicated to me a result of the differences in time in which the data was collected? Or were they a result of the different data collection methods? By being interviewed by an NGO staff member, the girl might have given a strategic answer, representing herself as a child in need. Although I am aware of such inconsistencies, these have on occasion been downplayed in my interest to identify broad patterns and trends.

The second and third quality criteria outlined by Gaskell and Bauer refer to procedural clarity and corpus construction. I hope that my transparent account of the procedures I followed to develop and generate my data corpus will allow even critics of qualitative research to appreciate my study for what it is. The corpus construction was dependent on the voluntary participation of children. I have previously discussed my difficulties with participant retention. This however meant that I primarily got the views of children who wanted to share their circumstances and had time and energy to participate. A few of the children who dropped out were so busy and burdened by the caregiving responsibilities that they simply could not continue to participate. Although their views were included in the photovoice exercise, they did not get the opportunity to communicate their views further at later stages of the research project. This may be a bias to the study and a possible limitation to the relevance of my results.

A fourth quality indicator is my extensive use of verbatim reporting of sources, or what Gaskell and Bauer refer to as 'thick description'. My aim has been to present quotations to illustrate all the themes that emerged from my thematic analysis. The thematic networks presented in each finding chapter included a tally count of the number of quotations relevant to each theme, serving as a relevance marker. However, as I have primarily looked at trends, relationships and negotiation processes, contrasting views have not received as much attention as I would have liked, possibly limiting the confidence the reader may have in my study.

There were a number of 'surprises' arising out of the analysis and write-up of this study. Whilst I set out to explore the coping strategies of young carers, as well as highlighting their role as social actors, I did not anticipate young carers to construct positive caring identities. Gaskell and Bauer say that surprises in qualitative research "help avoid the fallacy of selective evidence in interpretation" (2000:347). Whilst I had my eyes on social support strategies and expected children to engage in income generating activities, I did not expect the children to take such a significant role in negotiating access to local support. In a sense, my social psychology of coping was partly grounded from the data in an iterative process, highlighting the many unexpected observations.

The final quality criterion is communicative validation, which refers to a sharing and validation of findings with the study participants. Whilst I acknowledge the importance of entering into a dialogue with study participants, sharing my findings with them and hear what their take would be on my conclusions, this has not yet been done. I intend to write a simplified report of my findings and share it with the study participants to validate (or not) my findings. With the children and WVP

Kenya, I shall write up a short briefing paper and distribute it to NGOs within Kenya to share key lessons learnt. Nevertheless, this does not neglect the fact that the claims and interpretations made in this thesis are entirely mine and have not been discussed with the children.

8.3.2 Developing this thesis

Developing and executing this study, as well as writing it up, was by no means an easy job. The study was influenced by numerous factors, including the post election conflict that Kenya saw between December 2007 and until a coalition agreement was made by former UN Secretary-General Kofi Annan in February 2008. As I have stated earlier, at least 1,500 people were killed and 300,000 people were internally displaced during this conflict. With Bondo being the birthplace of Kenyan prime minister, Raila Odinga, the conflict had a catastrophic impact to the day-to-day life of people in the district. Violence and subsequent inflation meant that livelihoods were shattered by the conflict. Children could not go to school for two months and we should not underestimate the impact this conflict had on the youth clubs and the activities they were implementing as well as the retention of study participants due to their commitment to catch up with lost schooling.

Nevertheless, despite such external factors impacting on my study, the most influential and limiting factor to this thesis is me. I am not an impassive objective observer of the social worlds of young carers. As clearly stated in my introduction, the research objectives of this study were guided by my own personal observations as a development worker in Kenya as well as personal experiences as a so called 'young carer'. This background has clearly had an impact on the course and development of this study, the analysis of the data as well as my write-up. Some might argue that having an 'agenda' in this way is problematic. However, I believe all researchers have some kind of agenda or hypothesis they would like to prove right or wrong, and in the process of doing so bias their investigation.

Having said this, my theoretical framework was developed in an iterative process, partly influenced by my data, partly by my own observations and agenda and partly by a review of the existing literature. I therefore did not set out with a clear political disposition or theoretical framework that I wanted to prove, but slowly let it all come together. The structure of this thesis is therefore slightly misleading as it somewhat projects a linear process rather than the reality of the more circular process that guided my thinking and research activities.

This thesis must be read and understood against the limitations mentioned above. Nevertheless, this exploratory study has provided some important and initial insights to the lives of children difficult to reach and research, and I will in the next section outline how we can develop these insights further.

8.4 What is next?

8.4.1 Towards generalisability

In this thesis I have presented and discussed the lifeworlds of young carers (unique context) and supported them through a CCCT initiative (unique intervention). I have given detail to the cultural fabric that characterises this context, including the re-invention of the traditional *Duol* support network, now characterised by *Harambee* and numerous community organisations and church groups who forge links with some of the many international NGOs that are present in this particular context. I have also discussed local practices and the prevailing representations of childhood that are unique to this context and how these can facilitate or hinder the coping capabilities of young carers. What transpired from my findings is that these context specific characteristics influenced the outcome the CCCT intervention and had an impact on their lifeworlds, playing a key role in my findings. For example, it could be argued that the notion of *Harambee* and the culture of NGO support, played an all important role in bringing these children together for income generating activities – something which may not have been possible in a context characterised by less solidarity and commitment for collective action (no *Harambee*), or where people have no experiences of working with NGOs. Furthermore, it could be argued that my findings are too dependent on local representations of childhood, with for example age hierarchies and children's disenfranchised position undermining their capabilities to successfully implement CCCT activities – as illustrated by the theft of one guardian in Moja community. If these context specific systems and practices play a key role in the CCCT intervention, and form the backbone of any conclusions made in this study, how can I generalise and transfer the successes of the CCCT programme and any other conclusions presented in this thesis?

I would like to reiterate and draw on my discussion on generality in Chapter three and present three steps toward generality:

- I. I hope that through an open and transparent account of the cultural context, my methodological processes and 'thick description' of empirical findings that readers will develop a detailed understanding of the study, enabling an informed judgement of its generality on a case by case basis.
- II. My conceptualisation of a social psychology of coping, exemplified through OCC, may be of interest to other areas of study. The generalisability of my findings and conceptualisation can be confirmed or disconfirmed only through the application of my conceptual framework in other contexts.
- III. To facilitate this process, I have in this concluding chapter related my findings to other empirical investigations, adding, confirming or contrasting their observations, helping them toward generality. Towards the end of this chapter I offer suggestions and recommendations, based on my experiences and findings, which other researchers and health professionals can draw on to explore the issues that have arisen in this study further. The generalisability of my conclusions can therefore only be proven from their future use.

8.4.2 Implications for future policy and practice

The study has indicated that viewing young carers as 'passive victims' who suffer from poor mental health instead of active social beings is not only incorrect, but also counter-productive. A focus on the problems facing caregiving children rather than how the children themselves face problems overshadows the resourceful ways in which they cope with difficult circumstances in a context of HIV and AIDS. Such a narrow focus also diverts attention away from intervention strategies that are geared towards their needs, potentials and capacities.

It is therefore critical that NGO workers and researchers working with young carers problematise their tendency to universalise what are in fact their own very culturally specific assumptions about what should constitute a 'normal' childhood and mental health, and their tendency to implicitly or explicitly depict those fall outside these assumptions as 'at risk'. To overcome this dilemma, I have shown that by using PLA techniques (cf. Rifkin & Pridmore, 2001), such as photovoice and draw-and-write exercises, within the framework of action research, one is able to derive more child-centred and culturally appropriate perspectives of their psychosocial well-being that can facilitate meaningful support. I therefore recommend service delivery organisations to make use of PLA techniques to facilitate meaningful support.

I introduced a social psychological conceptualisation of coping and mapped out the social psychological resources that I found to hinder or facilitate the coping of children in at a community level. I conceptualised these six resources as the dimensions of an OCC. In my view, it is vital that service providers who seek to support young carers prioritise the promotion of these six social psychological resources through participatory projects, backed up by appropriate support alliances.

Whilst CCCT is not a new type of intervention and goes under many names, I hope to have highlighted the importance of facilitating programmes that provide communities with the resources (monetary and social psychological) to successfully target local needs through local responses, something which is only possible through participatory programme cycles. Factors determining the orphan competence of a community and children's agency are likely to differ across geographies and time, making it important for future policy and practice to take account of the local context of young carers on a case by case basis.

8.4.3 Possibilities for future research

Whilst my social psychology of coping has provided a valuable starting point for mapping out the coping strategies used by children, there is a need for further research into the ways particular coping strategies are shaped, enabled and limited by factors such as demographics, household composition, the availability of social support networks and the socioeconomic status of particular carer households. There is also a need for systematic exploration of the short and long term costs of caring for sick adults, compared to the short and long term costs of other related challenges such as child poverty in the absence of caring roles, as well as caring for adults with non-stigmatised diseases. Finally, more research is needed to look at the processes and outcomes of CCCT in

other contexts and to explore the pathways through which CCCT can enhance OCCs and thereby support orphaned and caregiving children.

8.5 Final thoughts

What this thesis has testified is that young carers can cope with very difficult circumstances and that a simplistic representation of children affected by AIDS as inevitably “vulnerable, scarred, and wary of life” (Kelly, 2003:61) does not do justice to their remarkable coping strategies. Whilst there has been some reservations about a focus on coping, given the extremely negative social circumstances of many children and households (Kesby et al., 2006; Rugalema, 2000), I believe that negative representations do not do justice to the remarkable engagement and ingenuity in coping which many children are able to demonstrate, even in conditions of desperation and struggle (Panter-Brick, 2002). What is more, the children not only cope with their own circumstances, but play a crucial part in helping communities cope with the devastating effects of the AIDS epidemic (Ansell & Van Blerk, 2004; Kuhanen, Shemeikka, Notkola, & Nghixulifwa, 2008).

Having said this, this thesis has also outlined the vulnerabilities of young carers, suggesting the need to strike a balance between seeing children as actors or as victims of socioeconomic changes (Abebe & Kjørholt, 2009; Kesby et al., 2006). Abebe and Kjørholt (2009) argue that seeing children both as competent copers, as well as dependents and vulnerable, demonstrates the interdependence and fluidity of their lifeworlds, which has been at the core of this study on young carers. Alongside my focus on coping, I therefore also had a parallel emphasis on the need for agencies to support young carers, encouraging them to draw on the social psychological resources evident at a community level, to facilitate the coping and psychosocial well-being of young carers.

Appendices

Appendix 1: Descriptive questionnaire for young carers (10-17)

Questionnaire

Area Name _____

I. Descriptive questions for child:

1. Child's Name/Study Number _____ Gender (circle) M F
2. Date of Birth ___ day ___ month _____ year Present age: ___ years ___ months
3. Where do you live? _____
4. Whom do you live with? _____
5. Who takes good care of you? _____
6. Do you take care of someone? _____ Who? _____
7. How many hours of care do you provide a day? _____
- 6 Do you go to school? _____ What standard, form or class level? _____
7. Status of your mother _____
(If the mother has died, give date of death: _____ is the cause known?
_____)
8. Status of your father _____
(If the father has died, give date of death _____ is the cause known?
_____)
9. Do you have siblings? ___ yes ___ no 3a. How many? _____
10. Do the siblings live with you? ___ yes ___ no ___ some do some don't
11. Who cares for you and your siblings (if any)? _____
12. How long have you lived with current caregiver/been on their own? ___ Years ___ months
13. Other information about how child came to be in current living situation:

14. How much time in a day, on average, does your care giver spend on you?

Appendix 2: Checklist for investigators

Checklist

Please check (✓) the circle when you know or have prepared the following:

Guidelines for doing an interview/group discussion

- Do not start an interview by asking a personal question. Do five minutes of chit/chat, perhaps find a common ground and reference point, gain trust.
- Always use open-ended questions. Yes and no questions do not yield much information.
- Be careful not to use 'why' too often as it may make the respondent defensive.
- Do not ask more than question at once and make sure there is a flow in theme in order not to confuse the respondent
- Avoid leading questions such as: 'Don't you think?' Or 'do you think?'
- Avoid using negative questions like: 'why did you not...?'
- Ask questions in third person/plural – distance the respondents from the issues under investigation. E.g. 'Where can children with no parents get support?' in stead of 'where do you [an orphan] go for support?'
- Do not put your opinion across, remain objective.
- Do not let your opinion interfere with the flow and the discussion.
- Always listen to the respondent and make sure you have understood the answer. If you are too busy concentrating for the next question, you may loose a good lead, which you should follow up.
- Do not be afraid of silence.
- If a respondent or the discussion generates good data related to our aims and objectives, use follow up questions and let them speak.
 - "Tell me about..."
 - "What happened...?"
 - "Do you know something else?"
 - "Can you give me an example?"
 - "What else can you tell me about...?"
- Inform the respondent(s) when you are changing topic.
- If the discussion is irrelevant to the aims and objectives, gently direct the discussion back using the topic guide provide.
- Be aware of your body language: avoid crossed arms and use a 'smiley' and welcoming voice. Be comfortable, but stay professional.
- Ensure the interview/group discussion does not take longer than 20/60 min but avoid looking at your watch every 10 minutes.

Before entering...

- Are you aware of the respondents and their characteristics?
- Are you aware of the aims and objectives of this study?
- Have you got a copy of the topic guide with questions?
- Have you double checked the digital recorder functions and brought extra batteries with you?
- Have you got refreshments with you?

Your introduction...

- Introduce yourself, explain the background and purpose of the study
- Inform the respondent(s) of how long this may take and double check if they are available to devote their time.
- Ensure confidentiality
- Ensure them of their right to leave the interview and refuse answering any of your questions.
- Ask them if you can record the interview, again, ensure confidentiality.
- Obtain verbal and written consent if possible.

Finishing off...

- Provide respondent(s) with a brief oral synopsis of some of the main points that came across. Respondents may thereby agree or correct any misinterpretations.
- Thank the individual(s) for their time and trouble.
- Provide the respondent(s) with an indication of how, where and when they will be able to access the findings of the study.

Have you read and understood 'Qualitative Research: Introducing focus groups' by Jenny Kitzinger? *BMJ* 1995;311:299-302 (29 July)

Appendix 3: Topic guides

Topic Guide: Life as children caring for adults (for young carers in phase 1)

“You have now been in our programme for almost 4 months and we have gotten to know a little bit about your background, all of which will help us understand what life is like for children who provide for adults.

We would however, like to hear a little bit more about your experiences as someone who (has cared for an adult in the past / currently cares for an adult). We want this to be an informal chat where you freely can tell us about your experiences and how you (are / were) coping with the responsibility of caring for an adult – and any of your feelings about these experiences”

“To get our conversation started, I would like you to start off by telling me about your first experience of providing care for a sick adult...”

- Can you describe to us how a typical day was for you when you provided care for your _____?
- What (were / are) your responsibilities?
- How old (were / are) you?
- Why was it you who was providing care?
- How did you cope with the situation at that age?
- What is your opinion about children of that age with such responsibilities?
- What were some of your responsibilities?
- How did you live up to them?
- Who sometimes came to help you?
- Where could you seek help?
- When you think back, how do you think you managed to cope with all this work and responsibilities? What kept you going and hopeful?

What did these experiences do to you?

- How has it shaped your personality and being?
- What has the experience taught you?
- In what ways has it changed your status in your community?
- In what ways has the experience changed your life?
- How are you doing in school?

Have there been times where you had to provide care for another adult?

- Are you caring for someone now? Who? What circumstances made you the carer?
- How has your previous experiences of caring helped you in providing care now?

What do you think about children providing care?

- What are the good things about children providing care for sick or old adults?
- What are the not so good things about children providing care for sick or old adults?
- You, as a child providing care, how are you different from other children in your community?

As you know, we are here to find out what life is like for children who is providing care for adults – so if you have anything else you would like to share with us, please feel free to speak your mind.

Thank you for your patience and your wise words.

Facilitators were trained to use follow-up questions and probes

Topic guide: Children and childhood (for adults in phase 1)

"I am here to discuss with you the meaning of childhood, what is childhood, when does a child become an adult and what duties are normal for a child to carry out? What is the role of children in your society? And I would like to hear of your perspectives on children who care for an ill parent."

1. What is a child?
2. What does childhood mean to you?
3. How should a child ideally be brought up?
4. What is the role of adults in bringing up a child?
5. How does a child become an adult?
6. How much time do children spend in helping out in a household?
7. What kind of duties do children typically have?
8. In your culture, what is expected of a child at the age of 5?
9. In your culture, what is expected of a child at the age of 10?
10. In your culture, what is expected of a child at the age of 15?
11. In your culture, what is expected of a child at the age of 18?
12. Who typically cares for the ill and the old?
13. What kind of caring do the children do?
14. Who supports the children in doing so?
15. Can you describe a typical day of a child of an ill parent? Ageing grandparent?
16. How does it differ from children with healthy and working parents?

Facilitators will be trained to use follow-up questions and probes

Topic guide: Children and childhood (for professionals in phase 1)

"I am here to discuss with you how you and your organisation understand childhood and deal with children affected by AIDS"

1. What sort of activities does your organisation do for children?
 - How long have you been doing that for?
 - Why did you set out to do this? What inspired you?
2. Who encourages you to do these activities?
How do they (or not) relate to the needs on the ground?
3. What are circumstances of children in Bondo district?
What type of children do we have?
4. Who, according to you / and your organisation, are the most vulnerable children in Bondo?
Why do you think that is?
How do they differ from other children?
5. What does it mean to be a child?
What are they supposed to do and be like?
What do they do?
When is a child loved/disliked by the community?
6. Can you describe the transition from childhood to adulthood?
How does Luo society think of childhood? Adulthood?
Why do you think that is so?
7. How is a typical child in Bondo brought up?
What are your thoughts on this?
What, if any, would you like to see changing?
8. How should a child in Bondo ideally be brought up?
 - What is the role of adults in bringing up a child?
 - What kind of duties do children typically have?
What are your thoughts on those? Is it appropriate? If so (or not), why?
9. What are your thoughts on children who spend considerable time caring for their sick and or ageing guardians?
What can be done to support these children?
What is the role of the communities?

Topic guide: Adult perspectives on the intervention (for adults in phase 2)

1. What do you know about the programme your child has been involved in?
 - What activities did they carry out?
 - How did they plan and implement these activities?
 - In what ways did the activities benefit the child?
 - In what ways did the activities benefit you?
2. Do you think children have the ability and competence to implement such programmes?
 - What competencies do the children have?
 - If not, why do think that is?
3. What support (if any) did the children receive from the community in implementing these activities?
 - If little support, why do you think that is the case?
4. After your child joined the club, have there been any changes to his/her mood?
 - Changes to his/her behaviour?
 - Changes to his/her attitude?
5. What are your recommendations for future programmes targeting children like we have done?

Dhluo version

1. Ang'o ma ing'eyo kuom program ma nyathini osebedo katirno ni?
 - Tije mage ma gise'nmo?
 - Ere kaka ne gitimo tijegi?
 - Yore mage ma tijeqi osekonye nyanthi?
 - Yore mage ma tijeqi osekonyie?
2. Iparo ni nyithindo nigi nyalo mar timo program ailani?
 - Myalo mage ma gin godo?
 - Kaponi onge, ang'o mimiyo iparo kamano?
3. Kony mane (Kaponi nitie) mane nyithindo oyudo kuom jogweng' eyor timo tijegi? Kaponi ne giyudo kong matin ere gima omiyo?
4. Bang' kane nyathi osebedo e club ni, bende nitiere pogrouk e kite?
 - Lokruok kor ka timbene?
 - Lokrouk kor ka pache?
5. Kwayo mane ma in-go kaponi nitiere chenro moro machal kamae manyalo biro mbele?

Topic guide: Children's perspectives on the intervention (for children in phase 2)

How are you feeling at the moment?

- Life
- School
- Family

How long have you been involved with WVP Kenya?

- Can you tell us a little bit about how it has been?

Tell us a little bit about you and your friends in the club

- How often do you see them? What do you do when you meet up?
- What have these new friendships meant to you?
- How do they help you?

What activities in the club have you enjoyed doing?

- What activities have you been involved with?
- Why did you enjoy doing x or y or z?
- What did you get out of doing x, y or z?

Can you tell us how you developed the action plan/proposal for the funds that you received?

- Who was involved in developing the proposal?
- How did you all agree to carry out certain activities?
- What was your role in developing the proposal?
- Who did not participate well in developing the proposal? Why do you think that was?

How did you select your committee?

- What is your role in the club or the committee?
- What do you think about the committee?

What adults did you have to involve in order implementing the activities?

- What was their role?
- How were they helping you?

What did you purchase for the money given to you by WVP Kenya?

- What has that meant to you?

How did you implement the activities?

- How do you share the responsibilities?
- What is your role in the activity (corn selling/poultry keeping/kale growing)?
- Can you tell us about your experience of working together with the other children?
- Have you learnt anything from implementing these activities?
- Have you learnt anything from working together with the other children?
- What difficulties and challenges did you face in the process?
- If another group of children were to benefit from this project, what recommendations would give?

After working with these children and WVP Kenya, how is your life now?

- Have your feelings changed?
- What are your feelings towards life?
- What are your feelings towards the future?

How is your relationship to the person whom you are caring for?

- Has it changed over the past couple of years?

What are your hopes and goals for the future?

- How feasible are they?
- How will you achieve those goals?

Dhluo version

1. Erp Kaka iwinjo esechegi kaluwore gi: -
 - Ngimani
 - Yor skul
 - Anyuolani
2. Isebedo gi WVP Kenya kuom kinde marom nade? Ok inyisa kaka osebet?
3. Nyiswa kaka in to kod osiepeni manie ma usebedogo kae. Inengi ga marom nade? Ang'o ma lutimoga ka uromo? Ere kaka bedonu osiepni osekonyou? To osiepno onyiso ang'o?
4. Tije mage ma usetimo ma ka itimo to mori?
 - Jije mage ma usebedo ka utimo?
 - Ang'o momiyoyo mori ka itimo x or y or z?
 - Ang'o mane iyudo kuom timo x, y or z?
5. Bende inyaro nyisowae kaka ne woso plan mar pesa mane uyudo?
 - Ng'ano gini mane nitie e loso plan no?
 - Ere kaka un duto ne uyie mar timo tije moko?
 - In tiji ne en ang'o e loso proposal/plan no?
 - Ng'ano maok ne participate e loso plan no? ang'o momiyoyo ipano kamano?
6. Ere kaka ne uyiro committee maru?
 - Tiji en ang'o e club no kara e committee?
 - Ang'o ma iparo kuom committee no?
7. Jomadongo mage mane uketo mondo okonye e timo tijegi?
 - Tijegi ne gin ang'o?
 - Ere kaka ne gikoniyi?
8. Ang'o gini mane unyiewo gi pesa mane amiu gi WVP Kenya? Ang'o ma mano osenyisou?
9. Ere kaka ne utiyo tijegi? Ere kaka upogo tijegi?
 - Tiji ne en ang'o e tiji (usa kodhi/piadho gwen/puro sukuma)
 - Nyisae gik ma ineno kuom tiyo kanyakia gi nyithindo moko?
 - Bende nitie gima isomo kuom timo tijegi?
 - Bende nitie gima isomo kuom tiyo kanyakia gi nyithindo moko?
 - Pek mage mane ineno kane utimogi?
 - Kaponi group moro mar nyithindo ne dhi neon ber e project nim ang'o giri mitnyalo ng'iyo?
10. Bang' ka isetiyo gi nyithindo wereni kanathier gi WVP Kenya, koro gimani chal nade?
 - Pachi oselokore?
 - Ineno nade kod ngimani?
 - Ineno nade kod gima biro mbele?
11. Tudruok mane manie kindi gi ngama irito?
 - Bende lokruok moro nitie bang' tigris moko mosekalo?
12. In kod geno mane ndalo mabiro?
 - Ere kaka genoni biro chopo kare?

Appendix 4: Community map workshop guide

Guidelines for community map workshop

Purpose: To introduce the importance of maps and to practice mapping.

Time: Three hours

Materials: Paper, pens, copies/examples of community maps

Step 1.

Explain that maps can help the community and WVP to understand the local situation and make decisions. It is very useful to make maps with the community at the start of a needs assessment because:

- Local people enjoy drawing maps and have a very accurate knowledge of their surroundings.
- Mapping gets everyone involved and used to visualising his or her knowledge.
- Maps show what the different peer groups think is important in their community. Together with the discussion that goes on while the map is being drawn, the facilitator (Vincent/Cellestine) can quickly raise awareness of different development issues in the community.
- Maps help to make sure that everyone can be reached and that no one is forgotten or 'invisible' within the community. They help WVP to plan home visits, identify different groups and sectors with different problems, foresee risky situations and find good times to hold meetings and do activities.

Step 2.

Display the example of a community map with an explanation above it. Explain resources maps and social maps.

Step 3.

Divide participants into peer groups according to age and sex and explain that they will be working with peer groups in the community. Invite each group to select a facilitator and draw a combined resource and social map of the community in which the needs is going to be conducted. Ask them to start drawing the boundaries of the community and putting in the main roads and paths before adding other natural resources and social features.

Step 4.

Help each group to choose a suitable place to get started (ground, floor, paper). Provide thick pens if needed but otherwise let people choose the materials they want to use (such as sticks, stones or seeds) and allow them to draw the map by themselves. Be patient and do not interrupt them. It's their map!

Step 5.

Bring the groups together and walk around to visit and discuss the maps from each peer group. Encourage people to ask questions about that are shown.

Step 6.

Make a list of all the ideas that have come up from the drawings and discussions and list any further questions that need to be answered. Use the digital camera to take a picture of the community maps.

This exercise is not the final needs assessment exercise. It is to make the children think and open up their minds and see, from a different perspective, what is available of resources in their community. This will prepare the children for photovoice exercise and triangulate our findings.

Guidelines for historical profiles workshop

Purpose: To introduce and practice drawing an historical profile

Time: 40 minutes

Materials: A copy of an historical profile example. Paper and pens.

Background

Historical profiles, often known as time lines, are diagrams in which a line is drawn to represent a period of time, usually in years or seasons, from as far back as the children can remember up until the present. (Some groups may even draw a time line to predict what may happen in the next ten years). Along this line significant events which have occurred in their lives and in the community are marked. Time lines may show:

- Changes in patterns of rainfall, soil fertility, and cropping patterns, times of malnutrition, hunger and diseases.
- When the children start school, left school, started doing different kinds of work, migration patterns/movement, when they met their best friend or other important people in their lives, community changes
- When a parent got ill, when a parent passed away, when child moves in with care giver etc
- The building of infrastructure, roads, schools, water pumps etc
- The impact of previous projects.
- Changes in administration, set up of community groups/CBOs

Historical profiles are good to provide us with an understanding of the present situation in the community and in the lives of the children.

Steps

1. Explain what historical profiles are and how they are used.
2. Show an example of your timeline. They can make drawings as well as write down their story line.
3. In small groups ask participants to think back in time as long as they are able to and ask them to construct an historical profile of their own community, using the categories listed above.
4. It can be drawn on the ground or on the table, but make sure everyone participates. If the children need more space for their time line, please give them a second page and staple the two pages together.

Template for historical profile

Study ID: _____.

Village: _____.

Date: _____.

Year

Description



Appendix 6: Daily routine diagrams workshop guide

Workshop - Daily routine diagrams

- Purpose:** To introduce and practice drawing daily routine diagrams and for us to get an insight to what a typical day in their lives look like.
- Time:** 90 minutes
- Materials:** An example of a daily routine map, exercise forms and pens.

Background:

These diagrams show the activities which people do over a period of 24 hours. They may look like a straight line, just like in the time line, or they may be drawn as circular pie charts. These diagrams are used to help children show how they spend their time. They can also be used to compare activities of children who are school going and those who are not school going, those with one parent and those with no parents.

When the children are explaining their diagram to the group, the facilitator (Vincent or Cellestine) can encourage the group to think of reasons for any differences between the diagrams. The daily routine diagrams help us to understand more about the things that affect their well-being and social development and also that of the project and the community.

Steps

1. Explain what a daily routine diagram is and how it can be used. Ask the children to share any experience they have of using this technique. Give them an example of a time daily routine map and discuss it.
2. Tell the children that they are going to draw their own daily routine diagrams – one diagram for a day in the week and one diagram for a day at the weekend.
3. Brainstorm a list of factors they may want to include, for example:
 - a. Work in the home
 - b. Work outside the home
 - c. Income generation inside the home
 - d. Income generation outside the home
 - e. Time for self, friends, school and relaxation.
 - f. Time spent on caring for others
 - g. Time for community activities
4. When the children have finished drawing their daily routine diagrams ask them to get together with participants who are of the same gender and age as themselves.
5. They can compare their diagrams, look for common patterns and make a group diagram (on newsprint paper) from the individual ones.
6. In a whole group display and discuss the group diagrams. Ask participants to think how this analysis of their daily activities relates to their own health and well-being.

Idea adapted from Rifkin and Pridmore (2001) 'Partners in Planning' – MacMillan: Oxford

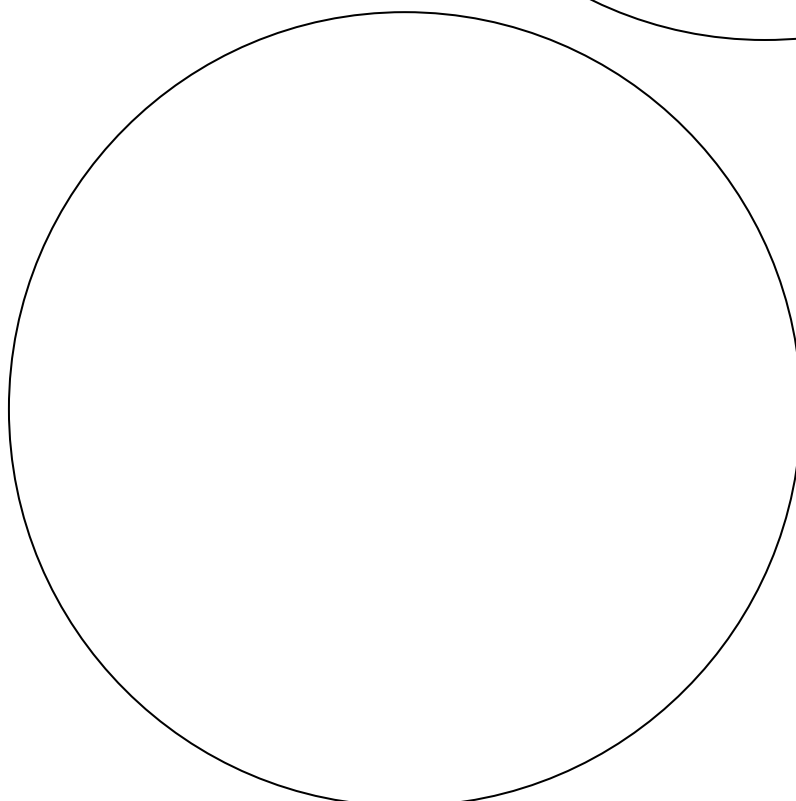
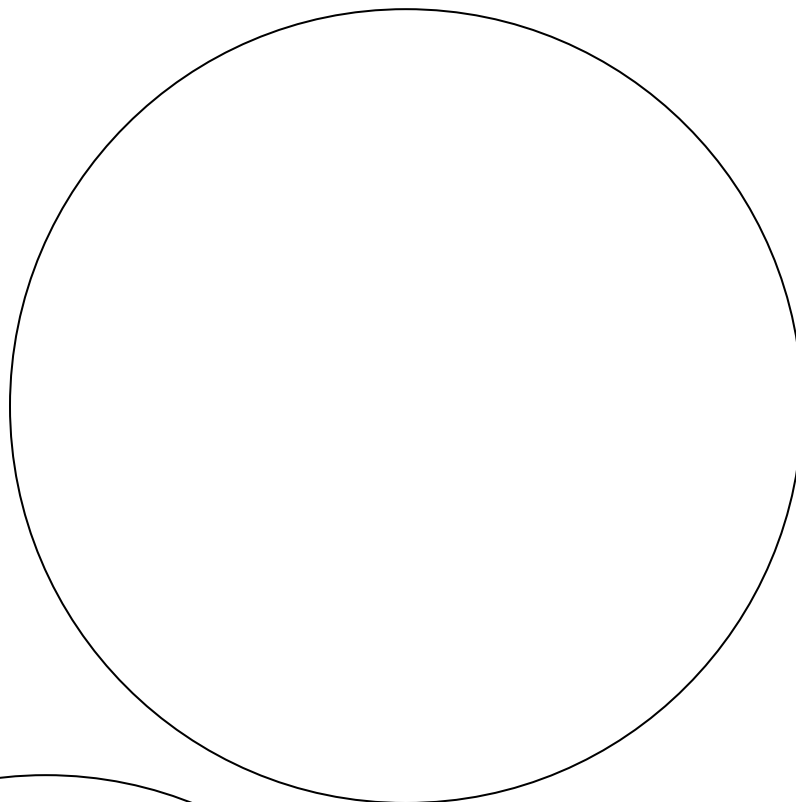
Daily routine diagrams

Study ID : _____

Village : _____

Date : _____

Week day



Weekend day

Appendix 7: Draw-and-write exercise workshop

Draw-and-write exercise

Tools:

- Plain white paper - For the drawings try and use quite good quality paper if you can - it may be the case that we make the pictures into slides, and the better quality the paper, the easier this will be.
- Some coloured pencils or pens for them to do the drawing
- Some lined paper for them to write on.

Guidance:

Please do this exercise in Dhluo language as they are more likely to write more. It is important we get the children to write as much as possible. Translate the drawing instructions below into Dhluo, photocopy and cut out the slips, so that each child gets a slip.

Give the children all three slips and ask them to read through them before they start. That way we avoid the children telling the same story more than once – tell them to have a think about the questions before they draw and write. They can decide what drawing to start off with.

Don't let the children sit right next to each other. Ask them to split up and sit individually. That way we avoid the children drawing and writing the same stories. Tell them to add their study number to the drawings and stories, not their names.

Give them one page for the drawing and two pages for the story. Remember to stable them together afterwards and confirm that the study number is correct.

If possible, don't rush them - give them as much time as they need to do the picture and tell the story.

As always, tell the children that the information they provide us is for the ongoing study and ask them if they are willing to participate – and reassure them that it is ok if they do not want to.

-

Draw-and-write exercise

- i. Draw a picture of the activities you carried out with funds from WVP Kenya.
- ii. Write a long story about how you and those in your household have gained from these activities.

-

Draw-and-write exercise

- i. Draw a picture of those involved in the project.
- ii. Write a long story (from beginning to the end) about how you organised yourselves to implement the activities
- iii. Write a long story about what you have gained from working together as a team.

-

Draw-and-write exercise

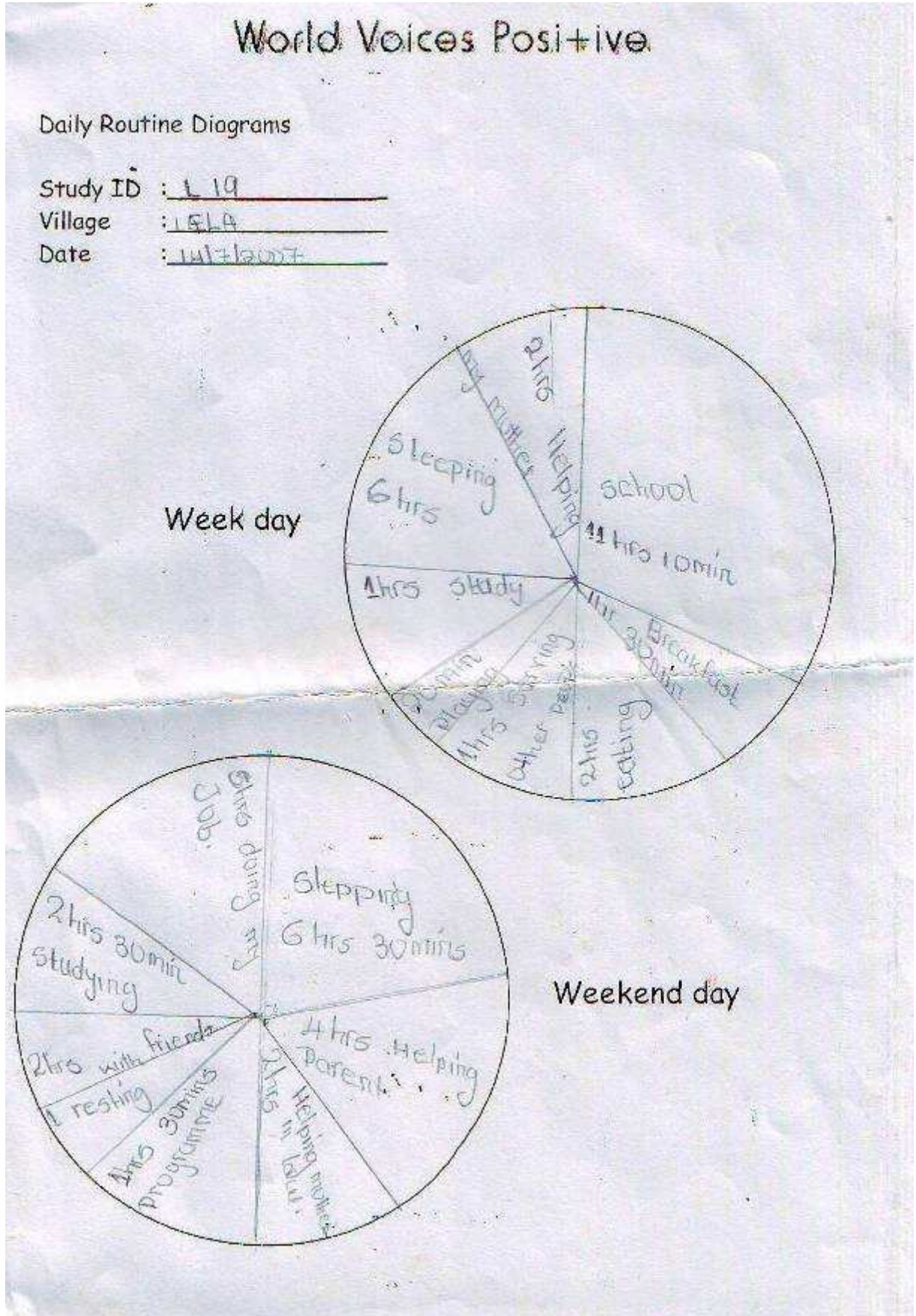
- i. Draw a picture of a situation where you faced a problem during the implementation of the project.
- ii. Write a long story about these problems and your recommended solutions.

Appendix 9: Example of history profile

Study ID: BP16
Village: Angeya
Date: 24/06/2007

- 1992: I was born in Kaloteni estate, Nairobi.
- 1998: My mother took me with her to Nairobi to study.
- 1999: I started nursery school, but shortly after left for home (Bondo).
- 2000: I went back to school and visited my sister during term one holiday in Yimbo, Nyamonye. I joined the same school and became number 2.
- 2001: My father started feeling unwell and was taken to Kibos hospital. He was treated and got better, but he was still not alright. May 2001, my sister took me to stay with her for a whole year near Kisumu. I went to school there up to class four. A word came from home that my father was seriously ill and that he was taken back to Kibos Road Hospital. After a week he died. The body stayed at the mortuary for a week then buried at home.
- 2002: My grandmother started feeling unwell and was admitted to Bondo hospital where she stayed for one month. She came back but was still ailing and was told by my grandfather to go back to the hospital but she declined.
- 2003: My grandmother died and her body was taken to the mortuary where her body stayed for three days and then buried. My mother too started feeling unwell, she went to the hospital and came back feeling relieved.
- 2004: My mother took me to Siaya to live with my grandfather. I joined class four, I studied there up to class five and came back home during holidays.
- 2005: I came back home and found my mother sick. She sent me to Siaya again to inform my sister to come back home so that I could remain and care for the children while she took my mum to the hospital. I was out of school looking after my sister's children.
- 2006: My sister came back, though my mother was still sick, I went back to school.
- 2007: I was in class 7; my mother became seriously ill during this year. I was forced to leave school to be with her. This year, Bo's mother came to me and told me of a group of people introducing a programme – they were World Voices Positive people. I joined the programme after going through signing documents giving consent to be part and parcel of the programme. Our parents were also called/invited and asked questions and signed consent form. They then presented to us volley ball net and balls and encouraged us to meet on the church ground.

Appendix 10: Example of daily diagram



Photovoice process

Aim

It is the aim of this PLA exercise to enable young carers better understand, articulate and communicate their experiences and circumstances. According to Foster-Fishman et al. (2005) this exercise has the potential to: 1) empower the orphans as experts in their own communities, 2) foster deep reflections, and 3) create a context safe for exploring diverse perspectives.

Process (step-by-step)

1. 48 young carers have been selected and verified to participate in this project
2. A three-hour photography workshop was arranged to cover the following:
 - a. Aims and objectives of the exercise
 - b. What we are interested in (theme: 'A typical day in your life'). The young carers should be asked to focus their photography and reflections around answering the following four questions:
 - i. 'What is your life like as a child providing care for an adult?'
 - ii. 'What is good about your life?'
 - iii. 'What or who supports you in your day-to-day living?'
 - iv. 'What needs to change?'
 - c. How to use a camera and take good pictures.
 - d. Ethical dilemmas with photography in public areas – this includes an explanation and dialogue about consent forms. The children are encouraged to think of scenarios where taking a photograph may not be appropriate and cause discomfort to those photographed. These scenarios are discussed and the children are told that if they want to share a story and they are unsure about whether it may be inappropriate to take the photo, or if they do not get an opportunity to take a representative photo, they can draw the scenario instead and describe their drawing(s).
3. The children have two weeks to take photos answering the above questions. After the two weeks the cameras shall be collected for development. Get two copies of each photo.
4. After development, the children are gathered in a workshop. They were asked, echoing the aims and objectives of this exercise, to pick six of their favourite photos that depict on or more of the following:
 - a. A photo that depicts something or someone that makes them happy or they enjoy doing.
 - b. A photo that depicts their role or responsibilities in the community
 - c. A photo that depicts something they lack, need, or wish they had more of.
 - d. A photo that depicts hope.(Again, if the children wanted to share a story and scenario they did not capture with the camera, they were encouraged to draw the scenario.)
5. The children must be told that the research team will use those six photos or drawings, but not the rest. The children write short essays to each with the following guidelines:
 - i. 'I want to share this photo/drawing because...'
 - ii. 'What's the real story this photo/drawing tells?'
 - iii. 'How does this story relate to your life and/or the lives of people in your neighbourhood?'
6. Scan each of the six photos/drawings picked by each child and return all hard copies and negatives to child.
7. Written narratives are analysed in Atlas.Ti

Appendix 12: Guidance on field note taking

Field notes

Investigators:

Vincent Onyango Ogutu
Cellestine Aoro
Morten Skovdal

Guidelines:

Keeping information in a logbook

The information that we collect must be written down so that we can use it for planning. A logbook is a small notebook in which we write down this information. We can then look back and see what we have learned so far in the planning process. The information we write down includes:

Plans for getting the information,

Information generated through interviews and observations,
Our insights and tentative conclusions,
Our own views and feelings about the process of generating information
You own observations and feelings of how the children cope and get by

The logbook is the record of the information that will later be used to support (triangulate) our findings. It is also a record of the way in which our plans and ideas develop in relation to new ideas and new discoveries. We need to start making the logbook when we first begin to seek information about a specific community and target population.

Example of a page from the logbook:

Village:	
Date:	
Interview/Workshop:	Notes:
WVP ID: xxx Observations	V or C Notes: Interpretations
WVP ID: xxx	
WVP ID: xxx	

On the left we can record the 'descriptive' information generated through the workshops, observations, interviews and discussions. You write what they say and do. On the right you write your interpretation of what they say/do your observations of the situation. But it is important to separate what they say/do and how you interpret it.

Other pages can be kept just like your diary, your thoughts and plans regarding young carers and the project.

Example of transcript: Individual interview extract

Interview Code: BP12-IDI
Interview type: In-depth Interview (1-2-1)
Investigator: Cellestine Aoro (=CA)
Village: Mbili
Duration: 24 min 45 sec.
Date of interview: 05/08/2007
Date of transcription: 08/08/2007
Date of Translation: 10/08/2007
Interviewee: Carolyne

CA: I want to talk to you about childhood and children, how they are helping and their lifestyle in general. What is it like to be a child in our community?

Carolyne: A child is // the duty of a child is to help parents. A child is called a helper because when a parent or guardian wants something which he or she is unable to go and get, they will send the child to go and get it. And that is a kind of help. Even if you don't have a child you will say: "I wish I had a child, he or she would have done this and that." For that reason, a child is a helper because he or she helps the parents.

CA: And how is life of a child in your community?

Carolyne: Children's lives are different. Sometimes a child is sick and another one may be well. One may be polite but you will not know what he or she is thinking. Sometimes you may see a child that is active, yet he or she is sick. Sometimes they are playful and sometimes they are weak. So children's lives are different.

CA: As a child, can you describe what a child can do in a day like today?

Carolyne: What a child can do after waking up? She can sweep the house. If it is a plastered house, she can mop, washing plates, preparing tea and if the parents are still asleep, she or he can wake them up and tell them that tea is ready. But they cannot take tea immediately after waking up. The parent may ask them to get them water to wash their face and a brush so they can brush their teeth. When this is done, that is when they can have tea. If the child is still too young to do these things, the parent will be responsible. The parent may also have to wash the bedding of the child. But if the child is a grown up, she and he have to assist the parents, she will wake up and prepare breakfast, sweep the house, mop the house and then awake the parents to take tea in case they were still sleeping.

CA: Can you think of any other examples?

Carolyne: The child has many duties. Sometimes after doing the household duties, she will fetch firewood to prepare lunch, fetch water if it is has run out, ask the mother if she can go and grind maize in case there is no flour in the house. She will tell the mother that the flour was used last night and there is no flour to cook ugali for dinner time. If the mother is able (has money), she will tell you to do this and that, but when she is unable (has no money), she will tell you that we can have strong tea [laughter]

CA: What would a child like to have more help with?

Carolyne: A child can need many things, like clothes, she will see a fellow child having a good dress and may even ask her mother to buy her one. Maybe a fellow child is playing with a toy and if the child is young, he or she would want the same. Sometimes the uniform is old and she is going to school, she may want a new one as some of her fellow pupils are having a new one and she does not. She may ask the mother to buy her a new one so that she can be in a new uniform like her fellow children. The child may also need shoes and socks for school to be like the other children. The children's needs are very many.

CA: Anything else?

BP12: Sometimes a child can go to her step-mother's house and find children eating maybe rice, chapatti and beans, taking tea with white bread, while in their house there is nothing to eat so the child will ask her mother to buy them this and that to eat. Even us we have that character [laughter] we may see that some people eating chapatti and means and us, we are eating ugali. The following day their diet may change to maybe tea with rice, whilst we have ugali again. Now, we may tell the mother to change the diet to something else.

CA: Yes, you are tired of Ugali?

BP12: We are tired of ugali, children are having a lot of it.]

Example of transcript: Group discussion extract

DATE OF INTERVIEW: 05/08/07
DATE OF TRANSCRIPTION: 11th & 12th August.
DATE OF TRANSLATION: 19th & 20th August
PLACE OF INTERVIEW: BAR PUOYO VILLAGE
TYPE OF INTERVIEW: FGD
TIME TAKEN: 38MINS 17SEC.
CHILDREN: 12CHILDREN (6boys & 6girls)
INTERVIEWER: C.A (Cellestine Aoro)

CA: We want to talk about a child, what kind of duties, caring that a child gives/does from these photos you've selected. What do you see in this first photo?

BP1: Cattle (cow/bull)

BP13: A person tethering a cow.

BP4: A cattle being vaccinated.

BP23: A house.

BP10: A person trying to locate the right place to administer on injection.

BP6: A person bent to tie the legs of a cow.

BP9: I can see a rope.

I can see a shed in the picture.

BP2: I can see grass.

BP4: A cow sleeping.

BP12: I can see trees.

CA: What is happening/story behind this photo?

BP1: The cow has been tied as if it is about to be killed though I don't see the items for slaughtering it around there. It also seems to me that maybe the cow was sick so they want to save her life and it looks like the cow is suffering from anthrax.

BP10: Since I know and usually look after the cattle, it seems that the cow is about to be injected, like I think that person is looking and trying to locate the right place to inject to heal the cow. Don't you my colleagues see the borne of this cow protruding or I'm I lying? (All are laughing)

CA: Anyone else? // any other story about this photo //

BP1: I think we keep animals, cattle, goats to help us in many ways. This can be sold and the money be used for other things. It is like the cow was about to die so the owner was just very mean to treat it. In future if it regain it's health, it may be sold to earn money for other activities.

CA: What do you think is happening here?

BP23: I think the cow is given a vaccination to prevent the spread of a disease//

BP12: This photo tells us that we should not just sit back. When we lack something in the house at home, we should try to find solutions, work hard even if it is dry, so we can cover our needs.

BP22: I think if you lack even paraffin, you can get this from these crops that we see in this photo after their sale.

BP4: I think the photo shows us that we should work hard on our farms to avoid laziness//

BP1: I wish to support BP4, since if we work hard on our farms, we can't beg anything from other people as in the case of this mother on her farm.

C.A: Why do you think this is happening? //

BP4: I think the mother is working hard to end poverty/fighting poverty out of her home.

BP8: I think she lacked money so she went to pick beans for sale to earn money

BP9: This is happening so that she could avoid suffering.

BP1: This mother ploughed, the crops somehow didn't do very well, and she is harvesting the produce to get seeds for next planting season.

BP12: I think that mother.....I think she is working/ trying hard to get something to eat together with her children, so they wont go without food.

BP4: I think she was harvesting her crops.

.....]

Examples of transcript: Photovoice narratives

L16(photo1)

I want to talk about my sister's illness from when it started to the time she died to rest in heaven. My sister started to get sick little by little and she was sleeping most of the time unable to do anything. She got weaker and weaker and this was at a time when my mother had gone to bury her father. I had no choice but to stay at home and be with her and feed her like as if she was a little child. She could not eat by herself and could only eat very small portions. When I finally noticed that she could eat something, I gained



some strength. I was washing her, washing her clothes and I gave her drugs within the correct intervals. I also cooked for her. I couldn't move away from her and applied oil to her body. What surprised me was that as soon as my sister heard my mothers voice upon her return from the funeral, she died. This really shocked me. Through this period I missed school on several occasions which was not good for me. When my mother returned and after the burial of my sister, I went back to school.

BP14(Photo3)

I want to talk about this picture because I hope they will help me and hope that if God is willing, will benefit me. The photo tells us that we should love and take good care of our animals. If we do that we can get a lot out of them and we can then help our neighbours through them. I love these goats, I am happy when look after them because they help me, they improve my health because if I sit down, I feel sleepy and at times if I don't take them out, I end up in the company of people who just talk about others which can cause



misunderstandings and that is why I feel it is good to look after these goats in the field rather than sitting down. My grandmother had a problem before I came to stay with her, being that her leg has a big wound. She was trying to get by, but couldn't and that is why I came here, to help her and that is why I am staying with her. At times, when my grandmother was alone, if she went out to buy drugs was very slow as she walks very slowly and she would come back late and not have time to look for the goats. When I came to live with her, to care for her and the goats, she got very happy. I really have great hope with these goats and God willing, if I am to go back to school, I can sell goats to get a uniform, shoes, socks and I can also help a child whose parents are sick, buy clothes for him or her. I take good care of these goats and they have gone into another person's plot.

Example of transcript: Draw-and-write exercise



This drawing is a sketch of my mother. At this day I was feeling very well because my mother was alive and we were in our home here in Yimbo. We are no longer in the town where we were living with my father. We lived there with him for four years and with my sister. During those days we lived in our house and my mother was looking after us, giving us food to eat. Sometimes my mother had no money to buy us food so we had to go our grandfather's house and ask for food. Fortunately my grandfather was not a bad person and he gave us whatever we asked for.

One day my grandfather called my mother and told her that she represents his son who was now dead and he wanted her to live with him. My mother was listening to his advice and did what he said. We were there for a year and we did not have as many worries as when we were alone. When she had no money to buy food she always thought of her husband and said, if dad was here, we would not have so many problems. Sometimes I picture him and see the joy of his face. As I am the first born and if I see this image I can even start crying of what happened to him. But since we started living with my grandfather I have been thinking of my dad less. As days passed my mother started feeling unwell. One day my mother said she wanted to go to the hospital. My mother was sick, but so was my sister. I was the only one who wasn't sick. My mother became seriously ill, could not eat, could not wash her clothes or wash herself. So one day my aunt came she told my mother that she would care for her and my sister. She took my sister to the hospital one day to see if they could treat her. I remained with my grandfather, but I was not looking after him for very long because I was going to school. As the days passed my grandfather called me to go and get my aunt. When I reached her place I told her what was happening at home and she told me that she would be coming with me back. When we got back and she saw her sister she started crying. I was also feeling sad, probably more than her as I had lost my father and now my mother was like this. My aunt went back, but after a couple of days they told me to go and get her again, the place is Usenge. They didn't tell me what was wrong, but I came back with my aunt we found my mother dead. My aunt said nothing and I was standing next to my mum just looking at her. But nothing which I could be saying would be heard by anyone, I was trembling standing next to her. My grandfather took me outside and we sat underneath a tree. I know what death feels like and I feel so bad about what has happened to me in the past.

Example of transcript: Essay

Study ID: BP22
DATE: 16/09/07

I have cared for a number of people; to begin with, when my father was sick. My father was a carpenter as well as a constructor. It was one day when they went together with his colleagues to finish a storey building. While there, he got up the building but by bad luck, he slipped and fell down. We thought he had died but by God's graze, he was rushed to the hospital and attended to. He broke one of the arms. My responsibilities/duties at that period were to ensure that I fetch firewood and take to Bondo market for sale. Our mother whom we were staying with (step-mother) was then taking firewood to the market then we attended him in the hospital and bought what he needed. When his condition improved, we took him back home. This was suggesting from his colleagues so that we could also home massage using herbs at times. Since he didn't want me to be away from him, I did everything for him; everything that he needed he could send me to get since his hands could not function. I could feed him with porridge, other food, water and he could only try bathing by himself. His friends/workmates could also visit him one after the other. He also got an herbalist who was coming home to massage him until he was fine enough to go back to work. But still could leave early for home, he could only squat while working on wood.

One day he became seriously sick of the previous sickness, he could not walk at all; he was vomiting, suffered from severe headache; I left school, at that time I woke up in the morning to wash utensils, light up fire to prepare for him what to eat more so porridge since he was having diarrhoea. His condition worsened and it reached a point where he was urinating and going for long calls in his bedding. I could wake up very early to check and take the bedding to wash in the lake (referring to River-Yala). While back, I find he has gone for long call again. I was those ones too and changed the bedding and clothes. I then prepared porridge and then rushed again to the river to wash the bedding.

The disease made his mouth to twist position and could not open properly; he was stroked on one side so I could not take him in and out of the house, he could not talk, couldn't do anything. I had left school and didn't imagine of going back to school again following my father's illness. I could struggle with him to take him out for long calls, whenever he needed anything; he could only point but not talking. I was straining a lot to know exactly what he wanted since he could not talk. Sometime when he wanted to go out to pass urine, he could just point and since I did understand most of these, I could at times. My mother (step-mother in the community) could console me saying he would be fine, but I didn't saw any sign of him becoming better so I continued crying. While on my way to the river going to wash his clothes bedding, some people could ask me on the way if I had a child or my mother has given birth. All those made me sob, I could not reply them. He continued with the sickness until he died.

I had also a certain mother who was our neighbour. She had given birth and her husband was lame. I was fetching water for them, washed utensils, cleaning their house. I also help a grandmother in doing the same duties as that mother. For this grandmother, I visit her to tell some stories. I have only assisted these people. I think all that I had done are good and will benefit me in future. I feel the people at home should jointly help the sick/old people out.

Appendix 14: Example of field notes

Example of field notes (from Cellestine)

Visit to Mbili community

On 9th march 2008, I went to Mbili and these are the children I found in the farm: -

1. John
2. Lucy
3. Kevin
4. Michael
5. Joyce

The children were busy watering their vegetables and some were digging. They were planning to plant some sukuma wiki in the evening hours and because most of them were going to school in the afternoon, they had to leave at around 12.30 pm and then will be back in the farm after school. On my way home, I passed near another home where I saw. I called her but she did not respond. I then sent some other children to go and call her but her brother refused and asked me what I wanted from his sister. He told me that she did not have time to chat. I then proceeded with our journey leaving her because I could not force myself into a home where I was not invited. I tried by all means to let her come to us but she was just sat there quietly.

I was told one week ago that Beryl had to leave the community to stay with her aunt after she lost her mother whom she had been caring for along time.

Then at around 6.15pm, Beryl came to our office accompanied by Joyce. She told me that she had just arrived the same day and came to the garden where she found that we had already left. According to her, she had just come to look into ways by which she can come to the programme every Sundays. It is due to lack of transport and that's why she has not been coming to the programme.

After the death of her mother, she was taken by her uncle who also went to Kisumu leaving her back at home with the wife. She told me that she has not been getting well because since the uncle went to Kisumu, he had not come and the uncle's wife is not working. According to her, she wanted to come back but there is nowhere she can stay. Though she was taken back to school, she could not go to class seven because she did not do the end year exams due to the illness of her mother whom she was taking care of. She had to repeat class six which she is now continuing with her studies. She also wanted us to help her on how she can be coming to programme because she don't want to leave the programme. I told her to come back after closing school so that we can discuss and see what we can do about it. She left promising to come back in April holiday.

Appendix 15: Thematic content analysis: from codes to global themes

Global theme: Dynamics and characteristics of lifeworlds

Codes	Issues discussed	Basic themes identified	Organising themes
<ul style="list-style-type: none"> - Expected to help out at home (5 children, 6 adults) - Developmental stages (1 child, 27 adults) - Value of children (3 children, 4 adults) 	<ul style="list-style-type: none"> • Child is a gift • Duties fit their abilities • Hard and collective work necessary to combat poverty 	<p>1. Adults have an expectation of children to help out sustaining the household. They are seen as an asset.</p>	<p>‘other’ childhoods – different perceptions of childhood</p>
<ul style="list-style-type: none"> - Changes to Luo society and childhood (27 adults) - Transition to adulthood (2 children, 22 adults) 	<ul style="list-style-type: none"> • Education of children • AIDS and other diseases • Influx of NGOs • Respect of elderly • Sexuality 	<p>2. The transition from childhood to adulthood has changed.</p>	
<ul style="list-style-type: none"> - Gender roles changed (1 child, 8 adults) 	<ul style="list-style-type: none"> • First born child • Boys doing ‘girl duties’ • Girls doing ‘boy duties’ • Poverty and gender 	<p>3. Disease and poverty has meant that gender roles are increasingly fluid.</p>	<p>Relationships between children and adults</p>
<ul style="list-style-type: none"> - Parent responsibilities (1 child, 11 adults) - Role of father (7 children) - Role of guardians (7 children, 5 adults) 	<ul style="list-style-type: none"> • Sexual health information • Meet the child’s needs • Discipline • Fathers are breadwinners 	<p>4. Parents and guardians have the responsibility of ensuring the children become responsible citizens and have access to their basic needs.</p>	
<ul style="list-style-type: none"> - Obedience (1 child, 4 adults) 	<ul style="list-style-type: none"> • Do what is told • Orphaned children are hard working 	<p>5. A good child is obedient and helps out at home.</p>	
<ul style="list-style-type: none"> - Respect for guardians (7 children, 4 adults) 	<ul style="list-style-type: none"> • Guardianship is valuable • Children know their disenfranchised situation • Pleasing guardians 	<p>6. orphaned children are grateful for their guardians and show deep respect. 7. children aim to please their guardians to avoid disappointing them.</p>	
<ul style="list-style-type: none"> - Love for guardian (12 children) - Love for parents (6 children) - Mutual care and support (23 children) 	<ul style="list-style-type: none"> • Reciprocity • Relationship • That’s what family does 	<p>8. Young carers and their cared for help each other through mutual care, love and support.</p>	
<ul style="list-style-type: none"> - Child rights (22 adults) - Lack of advice by elderly (6 adults) 	<ul style="list-style-type: none"> • NGO Trainings • Children’s department • Lack of respect • Lack of collective responsibility • Generational dialogue 	<p>9. Education and modernity has transformed adult/child relationships.</p>	
<ul style="list-style-type: none"> - Orphanhood (9 children, 21adults) 	<ul style="list-style-type: none"> • No longer a child of the community • Modernity • Increase in orphans 	<p>10. There has been changes to the notion of orphanhood. 11. Social and cultural changes has increased the vulnerability of children.</p>	<p>The emergence of OVC</p>
<ul style="list-style-type: none"> - Abuse and vulnerability (5 children, 8 adults) - Neglect (2 children, 1 adult) 	<ul style="list-style-type: none"> • Stepmothers • Violence • Discrimination of orphans versus non-orphans 	<p>12. Orphanhood is associated with abuse and discrimination.</p>	

Global theme: The circumstances and perceptions surrounding young carers

Codes	Issues discussed	Basic themes identified	Organising themes
- Disease and family background (26 children, 1 adult) - HIV/AIDS (9 children, 3 adults)	<ul style="list-style-type: none"> • Successive deaths of family members • Stigma • Symptoms and weakness 	13. AIDS is often a cause of caregiving.	Becoming a young carer.
- Cultural traditions impact (14 children, 9 adults) - Sent to care (10 children, 2 adults)	<ul style="list-style-type: none"> • Restrictions on who can care for who • Adult/child customs • Gender • Migration 	14. There are socio-cultural reasons to why children are likely to engage in young caregiving and occasionally sent away to do so.	
- Family circumstances (8 children) - Lack of support (11 children) - Need additional support (3 children, 2 adults) - Poverty (23 children, 8 adults)	<ul style="list-style-type: none"> • Poverty related struggles • Disease • Accidents • Struggles 	15. Young carers often come from poorer households and/or families with limited support.	
- Commitment to provide care/support (5 children) - Felt need to act (15 children) - Reciprocity (19 children) - Strategic caregiving (20 children)	<ul style="list-style-type: none"> • Always support the needy • Love for the vulnerable • No one else to do it • Reciprocating care and support 	16. Many young carers want to provide care and support – often driven by reciprocity, future support and social recognition.	Care recipients
- Duration of caring (5 children)	<ul style="list-style-type: none"> • Short-term • Long-term • Recurring 	17. Caregiving is rarely a one-off experience but a recurring duty.	
- Sick parents/guardians (36 children, 2 adults)	<ul style="list-style-type: none"> • Nursing duties • Head-of-household • Symptoms 	18. Many young carers provide care and support for ailing parents.	
- Caring for children (13 children)	<ul style="list-style-type: none"> • Younger siblings • Orphaned children 	19. Many young carers provide care and support for younger siblings.	
- Caring for community elders (6 children) - Caring for grandparents (45 children, 8 adults)	<ul style="list-style-type: none"> • Old age inabilities • Fetching of water and firewood • As children of the elderly die of AIDS, grandchildren need to take care 	20. Many young carers provide care and support for elderly people.	
- Young caregiving (46 children, 7 adults)	<ul style="list-style-type: none"> • Children help out with cooking and cleaning • Children of all age groups assist 	21. Children are important to household livelihoods.	Caring roles and responsibilities
- Child-headed households (19 children, 5 adults) - No rest (4 children)	<ul style="list-style-type: none"> • Primary source of income • Adult responsibilities • Missing school • Sustaining household 	22. Young carers contribute significantly to the household economy.	
- Personal care (33 children)	<ul style="list-style-type: none"> • Washing bodies and applying creams • Cooking, feeding and cleaning • Administering medication 	23. Young carers provide significant personal and nursing care.	Local perceptions of young caregiving
- Mental health support (5 children, 2 adults)	<ul style="list-style-type: none"> • Encouragement • Share happy stories • Being present and caring 	24. Young carers provide mental and emotional support for the sick and old.	
- Caregiving detrimental (19 children, 6 adults) - Culturally inappropriate responsibilities (4 children, 11 adults) - Perceptions of young caregiving (4 children, 15 adults) - Play (11 children, 2 adults) - They need help (6 children)	<ul style="list-style-type: none"> • Children should not provide that level of care • Culturally inappropriate • Little time to play • Negative impact on education 	25. Some perceive young caregiving as inappropriate and damaging to the child.	
- Self perception (26 children)	<ul style="list-style-type: none"> • Hard working • Different from other children • Good versus bad 	26. The children have mixed perceptions about young caregiving.	

Global theme: Challenges faced by young carers

Codes	Issues discussed	Basic themes identified	Organising themes
<ul style="list-style-type: none"> - Material needs (17 children, 1 adult) - Poor housing (12 children) - School fees and costs (10 children, 4 adults) 	<ul style="list-style-type: none"> • Lacking clothes • Lacking school related materials • Leaking houses 	27. The funds available to many young carers are inadequate.	Poverty and destitution
<ul style="list-style-type: none"> - Relative needs (9 children) 	<ul style="list-style-type: none"> • Comparing to other children • Not wanting to stick out 	28. Many children describe their needs in relation to what 'non-caring' children have.	
<ul style="list-style-type: none"> - Diet and Nutrition (10 children) - Food insecurity (5 children, 1 adult) 	<ul style="list-style-type: none"> • Lack of diverse foods • Ugali • Impact on the cared 	29. Young carers have a poorer nutritional intake and occasionally struggle to find food.	Psychosocial challenges
<ul style="list-style-type: none"> - Health problems (7 children) 	<ul style="list-style-type: none"> • Malaria • Dysentery • Hospital visits 	30. Young carers frequently suffer from malaria and waterborne diseases.	
<ul style="list-style-type: none"> - Stigma (11 children, 3 adults) 	<ul style="list-style-type: none"> • Hurtful words • Being different • Labelled as an orphan 	31. Stigma and ignorance causes fear and bullying.	
<ul style="list-style-type: none"> - Loosing a father (3 children, 1 adult) - Worry (8 children) 	<ul style="list-style-type: none"> • Loosing a father is seen as detrimental • Worry about the sick and the future 	32. Many young carers are worried about those around them and what the future might bring.	Managing both education and caregiving duties
<ul style="list-style-type: none"> - Parental bereavement (7 children, 1 adult) 	<ul style="list-style-type: none"> • Ailment • Death 	33. Many young carers have already experienced parental death at close hand.	
<ul style="list-style-type: none"> - Caring affects school performance (22 children, 3 adults) - Missing school (31 children) 	<ul style="list-style-type: none"> • Lack of concentration • Tiredness • Absenteeism • Busy with home duties 	34. The school performance and attendance of some young carers have been negatively affected.	Managing both education and caregiving duties
<ul style="list-style-type: none"> - Doing well in school (6 children) 	<ul style="list-style-type: none"> • Doing relatively well • Excelling in class • Catching up on work 	35. Many young carers go to school and do well despite their circumstances.	

Global theme: The social coping strategies of young carers

Codes	Issues discussed	Basic themes identified	Organising themes
- School, a place of joy (5 children)	<ul style="list-style-type: none"> • Being with other children • Aspirations 	36. The school gives young carers a sense of normality.	Community structures
- Schools supportive (10 children, 3 adults)	<ul style="list-style-type: none"> • Teacher support • Encouragement 	37. Teachers can be an important source of encouragement and support.	
- Blessings by God (11 children, 1 adult) - Spiritual support (8 children, 1 adult)	<ul style="list-style-type: none"> • Serving God • God recognises your work • Faith 	38. Children draw on faith and spiritual resources to give meaning to their circumstances.	
- Community support (31 children, 6 adults)	<ul style="list-style-type: none"> • Provision of meals and clothes • Empathy • Neighbours • Access to land for farming 	39. Children can negotiate support from community members.	Community support
- Community support groups (9 children, 10 adults)	<ul style="list-style-type: none"> • CBOs • Home based care groups • Faith based groups • Widows group • 'Harambee'/fundraising • Meals, clothes and fees 	40. Community based organisations and grassroots groups are a source of support for many children.	
- Togetherness and unity (5 children, 1 adult) - Peer support and friendship (16 children)	<ul style="list-style-type: none"> • Mutual support • Encouragement • Empathy and emotional support 	41. Notions of unity and togetherness, materialised through peer-led group support.	
- Sharing (10 children)	<ul style="list-style-type: none"> • Siblings share duties • Collective effort 	42. Members within households and the immediate family often share responsibilities in caring for the sick.	Family support
- Family support (35 children, 6 adults)	<ul style="list-style-type: none"> • Relatives have the primary responsibility • Aunts and uncles • In-law families 	43. The extended family steps in and support children when the immediate family is unable.	
- Benefits from livestock (23 children) - Benefits from poultry (13 children)	<ul style="list-style-type: none"> • Important source of milk and eggs • Animals can be sold • Offspring give hope • Animals an insurance during times of hardship 	44. Many children benefit from keeping animals.	Active engagement through agriculture and income generating activities
- Benefits from gardens (46 children, 1 adult)	<ul style="list-style-type: none"> • Vegetables can be sold and diversify diet • Growing (nutritious) food • Fruits can be sold or eaten 	45. Fruit trees and cultivation of gardens provided the children with an income and food.	
- Charcoal burning (17 children, 1 adult) - Income generation (19 children)	<ul style="list-style-type: none"> • Income generation and meeting basic needs • Charcoal burning harmful to health • Good money 	46. Boys often engage in charcoal burning and work for neighbours in hope for reciprocal support. 47. Girls sometimes do domestic work and sewing for neighbours.	

Global theme: The psychological coping strategies of young carers

Codes	Issues discussed	Basic themes identified	Organising themes
- Strategic caregiving (20 children)	<ul style="list-style-type: none"> • Appreciation by the cared for • Children receive thanks 	48. The children's duties are socially recognised and encourage them to care.	Finding positive meanings to caregiving
- Recommending to care (3 children)	<ul style="list-style-type: none"> • Recommend others to care • Future value • Independence 	49. The experiences they gain from their responsibilities are valuable.	
- Value (14 children)	<ul style="list-style-type: none"> • Gain coping skills • Independence • Stronger 	50. Some children see caregiving as a personal growth experience.	
- Caring beneficial (5 children)	<ul style="list-style-type: none"> • Self-satisfaction • Bright future • Pride • Caring makes them happy • They enjoy lighter duties 	51. Some children are able to focus on the successes and positives of caregiving and thus find enjoyment.	
- Caring makes me strong (3 children)			Ascribing negative meanings to caregiving
- Personal growth (5 children)			
- Punishment (5 children)	<ul style="list-style-type: none"> • Left alone with no support • Unpredictable disease 	52. Some children see themselves as a victims of external forces.	Ascribing negative meanings to caregiving
- Victims (13 children)	<ul style="list-style-type: none"> • Necessary for a prosperous future but compromised by caregiving • Lost time in school 	53. The impact of caregiving on education causes loss and damage to their future.	
- Importance of education (11 children, 5 adults)			Constructing positive identities
- Loss or damage (14 children, 1 adult)	<ul style="list-style-type: none"> • Loved by the community • Exceeding local expectations • Other 	54. Acknowledgement of caring roles help young carers construct a positive identity.	
- Acknowledgement of caring roles (7 children, 1 adult)	<ul style="list-style-type: none"> • Children an asset • 'Helping heart' • Prevent suffering • Loved by their community 	55. Many young carers see themselves as 'helpers'.	
- Loved by the community (5 children)			Hope and aspirations
- Helpers (19 children, 1 adult)	<ul style="list-style-type: none"> • Migration; new to village • Happily work • Disciplined • 'Helping heart' 	56. Young carers see themselves as being different other children.	
- Happiness (5 children)			
- Being 'other' (10 children)	<ul style="list-style-type: none"> • Occupational dreams • Educational prospects • Wish to help others • Hope for the future • God and religion 	57. Children hope their active participation in the community will benefit them in the future. Either through reciprocal support or from the skills they have gained.	
- Dreams and Aspirations (21 children)			
- Hope (6 children, 1 adult)			

Global theme: CCCT – A psychosocial intervention for young carers

Codes	Issues discussed	Basic themes identified	Organising themes	
- Division of labour and roles (15 children, 1 adult)	<ul style="list-style-type: none"> • Decision making • Skills focus • Labour • Gender • Committee members 	58. The children had different abilities and interests which influenced their roles and responsibilities in the project.	Project process and content	
- Drop-outs (18 children, 3 adults)	<ul style="list-style-type: none"> • Distance • Lack of time • No immediate benefits 	59. Time constraints and distance meant retention was an issue.		
- Parents invited (10 adults, 23 children)	<ul style="list-style-type: none"> • Called for advice and guidance • Do work whilst children are in school • Permission to participate 	60. The children strategically involved some guardians in the project to ensure its success.		
- Moja project (11 children)	<ul style="list-style-type: none"> • Selling of Maize • Profits • Purchasing of equipment 	61. The Moja project involved selling of maize.		
- Mbili project (48 children)	<ul style="list-style-type: none"> • Growing of Kale • Selling of vegetables at market • Poultry keeping and chicken shed construction • Purchasing of school equipment 	62. The Mbili project involved gardening, poultry keeping and purchasing of school uniforms.		
- Team work (50 children, 1 adult)	<ul style="list-style-type: none"> • Skills transfer • Sharing eases work load • Different agendas and interests 	63. The children have a balanced view of team work, its benefits and limitations.		Materialistic and practical outcomes
- Achieving more as a team (14 children, 2 adults)	<ul style="list-style-type: none"> • Generating more ideas • Work faster with more hands • Gain confidence in skills 	64. The children observed a number of benefits from working together.		
- Materialistic gains (40 children)	<ul style="list-style-type: none"> • Money • Food • School related materials • Chicken 	65. The children benefitted materialistically from the project.		
- Skills learnt (32 children, 4 adults)	<ul style="list-style-type: none"> • Poultry keeping and gardening • Running a business • Synergy of skills and knowledge 	66. The children have benefited from new coping facilitating skills.		
- Skills share and transfer (34 children, 2 adults)				
- Community project benefits (6 children)	<ul style="list-style-type: none"> • The community benefits from the availability of vegetables • Child-to-child education • Sharing of knowledge and skills • Sharing of problems • Coming to a resolution • Peace, love and unity 	67. There has been a wider impact of the children's participation on their community.	Social Psychological benefits	
- Wider impact (21 children, 4 adults)				
- Psychosocial support from friendships (19 children)		68. The project facilitated the development of supportive social spaces based on a strong sense of togetherness and unity.		
- Behaviour change (8 children, 4 adults)	<ul style="list-style-type: none"> • More social and proactive • Maturity • Respectfulness • Accepting carer role 	69. A number of children changed certain behaviours and attitudes as a result of their participation – including their sense of identity.		
- Reshaping identities (7 children, 1 adult)		70. For some children, the project led to an increased sense of empowerment and control.		
- Project ownership (1 child, 2 adults)	<ul style="list-style-type: none"> • Adults accept child ownership • Self-confidence/self-efficacy • Independence and control • Stronger and more proactive • Youth groups and unity • Skills learnt and knowledge gained 	71. Many children had expressed hope for the future as a result of their participation in the project.		
- Empowerment (15 children, 4 adults)				
- Future impact on project (8 children, 3 adults)				
- Negative parental involvement (14 children)	<ul style="list-style-type: none"> • Refuse children's participation • Involuntary involvement 	72. On occasions the parents involvement in the projects undermined the children's efforts.		Difficulties and challenges
- Committee causing problems (16 children, 1 adult)	<ul style="list-style-type: none"> • Corruption • Power • Lack of respect • Theft • Safe keeping • Management 	73. Some children felt that the project committee were to blame for problems faced.		
- Profit issues (5 children)		74. The children experienced some difficulties in managing the profits.		
- Work ethics (27 children, 3 adults)	<ul style="list-style-type: none"> • Laziness • Excuses • Only want to benefit but not work 	75. Laziness and differences in work ethics was prevalent.		
- Conflict (6 children, 1 adult)	<ul style="list-style-type: none"> • Fights and disagreements • Unequal workload and share • Laziness 	76. The children occasionally got into conflicts and disagreements.		
- Non-team players (4 children)				
- Theft (29 children, 1 adult)	<ul style="list-style-type: none"> • Theft by parents • Theft by fellow participants 	77. Theft was a problem for both projects.		
- Recommendations (40 children, 5 adults)	<ul style="list-style-type: none"> • Dialogue and involvement • Problem solving 	78. The children observed ways to solve problems and in which the programme could improve.		

Appendix 16: Ethics approval letter

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London WC2A 2AE
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16 May 2007

Mr Morten Skovdal
Institute of Social Psychology
London School of Economics.

**Professor
Sarah Worthington**

Deputy Director
Professor of Law

Dear Mr Skovdal,

Proposal: Young Carers in sub-Saharan Africa: Victims or Heroes?

I am writing with reference to the above research proposal and can confirm that the application has been independently reviewed by members of the School's Research Committee Ethics Sub-Group who concluded that the appropriate ethical safeguards would be in place for this project.

I can confirm that the School is willing to accept responsibility for the conduct of the research.

Yours sincerely,



Professor Sarah Worthington
Chair of Research Committee

REPUBLIC OF KENYA

MINISTRY OF GENDER, SPORTS, CULTURE AND SOCIAL SERVICE

Telegraphic Address: PRO/DEV/Kisumu
Telephone: Kisumu 2020083

When replying, please quote



DEPARTMENT OF SOCIAL SERV
PROVINCIAL HEADQUARTERS
NYANZA PROVINCE
P.O. BOX 1503
KISUMU

Ref No NY/FL/12/4 VOL V (10)


4th April, 2007

Mr Molten Skovdal,

WVP/LSE.

RE: SUPPORT/RESEARCH ACTION RESEARCH PROJECT:

Based on your previous collaboration with the community capacity support Programme, and your continued support to the communities in Bondo This Office has no objection for you to carry out the action research project on Young Carers in Sub-Saharan Africa Victims of heroes


GEKONGE J.G.
PROVINCIAL DIRECTOR OF GENDER AND SOCIAL SERVICES
NYANZA PROVINCE

cc
The District Gender Social Development Officer,
BONDO DISTRICT.

WVP
Vincent Onyango
P.O. Box 304,
BONDO.

Statement of consent: Adult qualitative interview

Purpose of interview/FGD

You are being asked to participate in a research study under the direction of Morten Skovdal from LSE and World Voices Positive. The purpose of this research is to explore ideas and feelings about children who care for sick adults, and discover appropriate ways to provide support.

Duration: Your participation in this interview/FGD will take no more than 30 min/90 min

Procedures:

If you choose to take part in this study, you will be asked questions about beliefs about health, HIV/AIDS, children, childhood, orphans, community support, and family. The interview will be lead by a trained local researcher from World Voices Positive. The interview will be digitally recorded and notes will be taken. No names will be used during the interview or in the recordings or on the notes.

Risk and discomforts:

There are no physical risks or discomforts associated with your participation in this study. The interviewer is trained to help you if you want to talk about any issues that come up in the interview. Nothing which will be said will jeopardize our partnership. Should you feel uncomfortable, please let us know immediately.

Benefits:

There may be no direct benefits to you from your participation in this study. However, knowledge gained from this study may contribute to an understanding of children and their health needs in your community, providing us with information, which potentially can benefit children and communities elsewhere in Kenya.

Confidentiality:

Every effort will be taken to protect your identity. We are not asking for your name and no participant will be identified in any report of this study or its results.

After you have completed the interview/FGD, we will store the information in a secure place. We store all information in a locker. Only information about the whole group of participants will be written up, and it will not be possible to identify any one person.

Right to refuse:

Your participation in this study is voluntarily, which means you do not have to do it if you do not want to. You can stop at any time without penalty or judgement. You may also refuse to answer any of the questions.

Subjects Agreement:

'I have read or have had read to me the information provide above. I voluntarily agree to participate in this study – knowing that I can refuse to answer any of the questions and stop participating without any penalty.'

Name of respondent

Signature of respondent

date

Name of interviewer

Signature of person obtaining consent

date

Statement of consent: Child qualitative interview

Purpose of interview/FGD

You are being asked to participate in a research study under the direction of Morten Skovdal from LSE and World Voices Positive. The purpose of this research is to explore ideas and feelings about children who care for sick adults, and discover appropriate ways to provide support.

Duration: Your participation in this interview/FGD will take no more than 30 min/90 min

Procedures:

If you choose to take part in this study, you will be asked questions about beliefs about health, HIV/AIDS, children, childhood, orphans, community support, and family. The interview will be lead by a trained local researcher from World Voices Positive. The interview will be digitally recorded and notes will be taken. No names will be used during the interview or in the recordings or on the notes.

Risk and discomforts:

There are no physical risks or discomforts associated with your participation in this study. Some questions however, may bring out emotional discomfort. The interviewer is trained to help you if you want to talk about any issues that come up in the interview. Nothing which will be said will jeopardize our partnership. Should you feel uncomfortable, please let us know and we will stop the interview immediately.

Benefits:

There will be benefits to you from your participation in this study, through support from World Voices Positive. Additionally, knowledge gained from this study may contribute to an understanding of children like yourself and your health needs. This information can potentially benefit children and communities elsewhere in Kenya.

Confidentiality:

Every effort will be taken to protect your identity. We are not asking for your name and no participant will be identified in any report of this study or its results.

After you have completed the interview/FGD, we will store the information in a secure place. We store all information in a locker. Only information about the whole group of participants will be written up, and it will not be possible to identify any one person.

Right to refuse:

Your participation in this study is voluntarily, which means you do not have to do it if you do not want to. You can stop at any time without penalty or judgement. You may also refuse to answer any of the questions.

Subjects Agreement:

'I have read or have had read to me the information provide above. I voluntarily agree to participate in this study – knowing that I can refuse to answer any of the questions and stop participating without any penalty.'

Name of respondent Signature of respondent date

Name of interviewer Signature of person obtaining consent date

Statement of consent: Use of cameras and study participation (English)

Purpose of photography and video recording

The purpose of this exercise is to give you a chance to speak out and show adults in your community and abroad what your life is like, what you like about it and what you like to see changed. After the photos have been processed we will talk about the pictures in groups.

Duration:

Your participation in this exercise will be a 36 months

Procedures:

If you choose to take part in this exercise you will be asked to take photos and video record 'A typical day in your life'. We would like you to answer three questions through photography: 1) 'What is your life like?' 2) 'What is good about your life?' 3) 'What needs to change?' You must always seek permission from the people you film or photograph and get them to sign in your own consent booklet. After processing the photos; we will meet up and talk about some of the photos, what they mean and what they represent. In signing this form you also agree to participate in the group discussion and writing essays on three of your favourite photos.

Risk and discomforts:

There are no physical risks or discomforts associated with your participation in this study. Some questions however, may bring out emotional discomfort. The interviewer is trained to help you if you want to talk about any issues that come up in the interview. Nothing which will be said will jeopardize our partnership. Should you feel uncomfortable, please let us know and we will stop the interview immediately.

Benefits:

There will be benefits to you from your participation in this study through the support from World Voices Positive. Additionally, knowledge gained from this exercise may contribute to an understanding of children like yourself and your health needs. This information can potentially benefit children and communities elsewhere in Kenya.

Confidentiality:

Every effort will be taken to protect your identity. We are not asking for your name and no participant will be identified in any report of this study or its results. However, your face may appear on photos and on video recording. After you have completed the interview/FGD, we will store the information in a secure place. We store all information in a locker. Only information about the whole group of participants will be written up, and it will not be possible to identify any one person.

Right to refuse:

Your participation in this exercise is voluntarily, which means you do not have to do it if you do not want to. You can stop at any time without penalty or judgement. You may also refuse to answer any of the questions. You must always seek consent of participation of the people whom you photograph or interview through video recording and inform them that they have a right to refuse.

Subjects Agreement:

CHILD 'I have read or have had read to me the information provide above. I voluntarily agree to participate in this exercise – knowing that I can refuse to answer any of the questions and stop participating without any penalty. I will receive a copy of all photos; however, I give the research team permission to use my photos confidentially. I will also make sure that any people I photograph or interview with the video camera has consented and is aware of the purpose of this exercise'

GUARDIAN 'I have read or have had read to me the information provide above. I allow my child to participate in this exercise – knowing that he/she can refuse to answer any of the questions and stop participating without any penalty. He/she will receive a copy of all photos; however, I give the research team permission to use the photos confidentially'

Name of respondent Signature of respondent date

Name of interviewer Signature of person obtaining consent date

Statement of consent: Use of cameras and study participation (Dhluo version)

Ng'is gima in

Ng'is ng'ama winji nyingi, qima omiyo in kanyo kod gima ingeyo kuom chenro mar konyo nyithind kiye. Ler-nigi tije ma chenro mar konyo nyithind kiye tiyo. Nyaka ing'e ni jokanyo ong'eyo kaka nyalo tudre kodwa kaponi gin gi penjo moro amora.

Gima omiyo wamiyou pichani

Gima omiyo watimo tijni en ni mondo omiyo thuolo mar wuoyo mondo inyis joma dongo kaka ngimani chalo, gima ihero kuome kod kaka idwaro neno lokruok. Bang' ka pichego osewuok, wabiro loso kuomgi e grube,

Thuolo momiyi/main-qo

Kindeni mar tijni biro kawi juma achiel.

Kaka ibiro time

Kiyiero mar tiyo tijni, ibiro kwayi mondo igo pichni wabiro dware mondo idwok penjo adekgi:

Ngimani chal nade? 2) Ang'o maberni ekit n'gimani? 3)Ang'o monego lokre?

Jumbe ariyo bang' kusedwokonwa pichni mondo odhi oluoki, wabiro romo mondo walos kuom pichni moko, tiendgi kod gima ginyiso. Eseche ma ibiro goyo seyi e fom ni bende niye ni ibiro tiyo kaachiel gi grubi no.

Gima rach kod gima nyalo miyo ibed maonge gi kwe.

Onge gima rach kata manyalo miyo ibed maonge kwe kaponi itiyi tijni. Onge gima ibiro wachi mabiro ketho/wuoyo chenro mar konyo nyithind kiye. wan kae kaluwore kod thuolo moa kuom "funding body." Kaponi ineno ni ionge kod kwe, wakwayi ni mondo wang'e mapiyo.

Ber mubiro neno:

Pichni go kosewuok to ubiro bedo kodgi kaka meku. Gima ibiro wachono biro konyo kuom winjo tiend chenro mar konyo nyithind kiyeni kuom kiye, ka gimiyowa gik ma wapuonjore, manyalo konyo kiye kod gwenge moro amora e Kenya.

Siri:

Wabiro temo mondo wageng' gimoro amora kik ng'ere. Ok wabiro penjo ng'ato ang'ata nyinge to bende onge ng'ato ang'ata man ka ma ibiro ful nyinge kata gima otimo etijni kata gima biro wuokie. Bang' ka usetieko tijni kod mag grubeu, wabiro kano wechegi kuma ber ma igoyo kiful. Kuom wechegi onge ma ibiro nyis ng'ato ang'ata.

Ratiro mar tamruok.

Mondo mi ibi e tijni, en mana kuom yie mari. Emomiyo ok ochuni ni itime kaponi ok idwar. Inyalo weyo sa asaya to onge gima itimoni. Bende inyalo tamri duoko penjo moro amora.

Winjrouk

NYATHI | 'Asesomo kata ose somna weche man malogo, ayangra mondo ati tijni ka ang'eyo ni anyalo tamra duoko penjo moro amora kata weyo tiyo kodu maonge kum moro amora. Abiro yudo picha achiel achiel kuom pichego duto; to bende ayie miyo joma tiyo kodwa rusa mar tiyo kod pichni na eyo mowinjore'

JARIT NYATHI | 'Asesomo kata ose somna weche man malogo, a yie ne nyatnina mondo ati tijni ka ang'eyo ni anyalo tamra duoko penjo moro amora kata onyalo weyo tiyo kodu maonge kum moro amora. Obiro yudo picha achiel achiel kuom pichego duto; to be ayie ni joma tiyo kodgi rusa mar tiyo kod pichnigo eyo mowinjore'

Seyi / 'finger print' mar nyarthi

Tarik

Seyi mar ng'ama tiyo tijni

Tarik

Extract from interview with Carolyn (focus on caring experience)

Date: 05/08/2007

CA: Yeah, that is not good. Let's move on to something else. Do you help out at home?

Carolyn: Now I am living in a home with two mothers. The step-mother may lack something but has nobody to send, she will say that she doesn't have water to bathe and will ask me to go and fetch water, and also firewood so that I can good ugali. Sometimes during lunch time, and you know that mothers are not as active as children, so I just got and fetch firewood. She will ask me to get her such and such. Maybe the flour is in the house and she will ask you to go and get it, she may also ask you to cook for her vegetables while she is still resting. Now, you can help with such duties.

CA: Apart from that, is there anything else?

Carolyn: Apart from that?

CA: Yes

Carolyn: Maybe she is away and there are younger children who needs to be taken care of. You can find yourself washing the children, feeding them and you make sure the poultry are well sheltered in the evening. In the morning you mop the house, fetch water for her so that in case she comes, she will find it ready. Those are the duties we can perform at home.

CA: How is the life of children caring for the sick?

Negative meanings

Carolyn: Their life is not good because sometimes the grandmother is sick, you wash her, you fetch water, you cook for her whatever she can eat. In fact you are so committed to the caring that you do not have time to rest. Sometimes you see other children resting while you cannot rest because if you do so, the workload will increase. Their life is not good because they are overworking and have no time for resting. You just work throughout until you go to sleep. Sometimes the person is so sick that you don't even sleep at night. You need to be awake such that when she needs something at night, you provider her with it. She may ask for drinking water, have no time to rest, you work throughout the day, no time for resting.

CA: Very tiring. Can you think of other things children can be required to do?

Carolyn: The duties they perform are like // sometimes she is sick but can bathe on her own and put on clothes herself but she cannot perform heavy duties like carrying water, fetching firewood and going to the farm. You may tell her: 'Grandmother, the garden is bushy, is there a jembe so that I can weed it?' You can fetch water, firewood, you can cook because there are some diseases in which is not good to sit next to the fire and then you can cook for her and help her with other small duties. But if she is very old and cannot do anything, you will have to wash her, put on her clothes, wash her dirty clothes. You know, an old person has a lot to be done for her, because sometimes she cannot eat by herself and you have to feed her. The old grandmother is different from somebody else who require duties because she has no energy to do that.

CA: What about the children who care for the sick and the old, whom do they get support from?

Carolyn: Like now I am living with my mother's sister and if I want to help the grandmother, she is the one who gives me the authority to do so if I am through with household duties. I can then go and assist so and so. She can tell you to go and prepare for her food and she gives you the food, because you have nowhere else to get food unless you are given by your mother. She can also give you soap to go and wash her clothes or she can give you Ksh10 to go and buy soap for washing of clothes. You know, one has to help you in helping the old grandmother.

Extract from caring essay by Carolyne

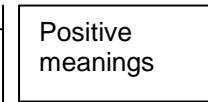
Date: 16/09/2007

I was first caring for my mother when she was sick and admitted to the hospital. She was too sick to do anything, so I was the one to wash her, support her to stand or sit when I was feed her.

I could give her porridge using spoon, since she could not eat on her own. When she had to go to the toilet, I gave her the basin then I disposed it in the toilet. Her condition then improved a little bit and she was discharged.

Her condition then worsened at home after a few days, it reached a point where I could not sleep at all. She was crying of pain all the time. She needed water, after some time she wanted to be massaged; she was never settled at all. I had to wash her, change her clothes and put her to sleep. I also did the other house work such as cleaning the house, washing utensils and fetching water. After this I prepared for her food and as I did all those, I kept on checking on her since she needed water and had to have her position changed all of the time. After I had prepared her food, I left it to cool and then supported her to sit and fed her.

I had to leave school since she could not be alone due to her serious condition. I then took her back to the hospital at the time when her condition worsened; she could not talk at all. I knew she was dying on the way but we went up to the hospital. She was admitted; we stayed there for two days. Her condition was improving but she died soon after. After burial, I went back to school and after a short while, my grandmother also fell sick and I started caring for her. I was going to school and I did the house work. I was fetching water, cleaning utensils, fetching firewood and prepared food for her. It reached a point when her condition got so bad that she could not even walk, sit or stand. At that time, I left school since she was seriously sick such that she could not even eat by herself, could not stand. I could wake up very early in the morning, sweep the house then prepared for her what to eat, fed her, spoon fed her in case she was having tea and porridge, then I washed the utensils, fetched water, washed her clothes and then fetched firewood and began preparing dinner. Since there was no money, I could not take her to the hospital, I was with her at home until her death. **In my life, I think all these I did were important and good. I think God will bless me.**



Positive meanings

Appendix 19: Example of coding process using Atlas.Ti

Date: 15/07/09

P 8: BP13-IDI.doc

Page: 1/7

001 **BAR PUOYO VILLAGE-CHILD INTERVIEW-
ENGLISH VERSION.**

002

003 *DATE OF INTERVIEW:* 05/08/07

004 *DATE OF TRANSCRIPTION:* 20/08/07

005 *DATE OF TRANSLATION:* 27/08/07

006 *PLACE OF INTERVIEW:* BAR-PUOYO
VILLAGE

007 *TYPE OF INTERVIEW:* IN-DEPTH
INTERVIEW (ONE TO ONE)

008 *TIME TAKEN:* 22MINS,
25SEC.

009 *CHILD:* BP13

010 *INTERVIEWER:* C.A
(Cellestine Aoro)

011

012

013 **C.A:** Now I'm here to talk to you about a child's life, how a child is growing, what a child undergoes and children who care for the sick and the old. Now what is a child? Just say anything you know about a child? //

014 BP13: A child is a young person.

015 **C.A:** How is the life of a child?


016 BP13: Sometimes a child may grow healthy or sick. There are certain things that he may lack.

017 **C.A:** Like?

018 BP13: Like clothes and even when he/she is sick, he should be taken to the hospital.










019 **C.A:** Now can you explain what a child does in a day, just a child whether big or small. What a child does in a day like today? //

020 BP13: Me as a child when I wake up in the morning, I wash my face, prepare tea, sweep the house, prepare myself, take tea, give my younger brother porridge when my mother is still washing clothes. After that I come here, I come to Bar puoyo and after discussion, when I go back, I light fire, cook when my mother is tired, then we make stories and then we go to sleep. The following day when people are going to school, I wake up, wash my face, take my breakfast, I then leave for school after sweeping the house. Now when I come back, I find food has already been cooked or sometimes the food

 Health problems

 Poverty

 Young caregiving and duties

- is not ready. Now I light jiko, cook ugali and my younger sister fry vegetables while I wash the dishes and then go back to school. Now after school that is 6.00p.m, I come back and wash dishes, I cook and my younger sister prepares porridge and milk, now I can just assist her.
- 021 C.A: **Now how many children are you?**  Caring for children/siblings
- 022 BP13: We three children.
- 023 C.A: **Are you the 1st born?**
- 024 BP13: Yes.
- 025 C.A: **Now what makes a child happy?**  Challenge  Ha
- 026 BP13: According to me, what makes me happy most is when I assist somebody; fetch water for my mother or when I work hard and obtain a number I was targeting, I become happy. Even when I assist my siblings, I become happy because they have got a support from me.  Caring is good
- 027 C.A: **Another one?**
- 028 BP13: I can assist other people, like there was an old grandmother in those sides of our area, I used to assist her because she gave birth to two children of whom one is abnormal and one is in town. The one in town used to bring clothes and even a sack of maize. There are some boys who normally come and carry the sacks away. Now I normally get for cigarettes and I normally wash her plates and I fetch for her water and that makes her happy.  Caring for community elders
- 029 C.A: **Now what are some of the things that children need others to help them with?**  Need additional support
- 030 BP13: Somebody can need someone to help him/her with clothes, books in case he/she lacks or even if the parents are all dead, they need someone who can stay with him/her and take care of him/her.  Material needs  Role of guardians
- 031 C.A: **Now is there anything that had happened to you in the past that when you think of make you sad and would like to share with us?**
- 032 BP13: Yes.
- 033 C.A: **What is it?**
- 034 BP13: One day I went to school and after reaching school, I placed my bag in class together with a report book and a Kshs. 200/= which  Family circumstances

I was given to go and pay fees. Now after preps, I went to my bag to get the Kshs. 200/= I was to pay but I couldn't find the money. I tried to ask my desk mates but they told me that they have not seen any thing. When I took the matter to the teacher, he asked me why I had not paid the money before but I told him that I didn't know that it was being collected at that time. Now I just go to class and later on when I went back home, I told my father but he insisted that the money is not lost, I'm the one who has it. Now after saying that, he gave me another Kshs. 200/= which I went and pay immediately then my father went to school and told teachers that when I'm given money to pay, I just eat them up.

035 C.A: **Another one?//**

036 BP13: Nothing else.

037 C.A: **Is your father around?**

038 BP13: Yes.

039 C.A: **What about mother?**

040 BP13: Also.

041 C.A: **Where is the father?**

042 BP13: He normally goes home on Saturday and Sunday. He doesn't normally sleep in our house even if he is around, he normally sleep in my step mother's house because she normally leaves for Kisumu at 4.00a.m to go and get clothes for sale. Now he normally comes on either Monday or Tuesday once.

043 C.A: **Why is it that he doesn't sleep in your house?**

044 BP13: Because there a child is sick but even us our child is sick but I don't know the reason why he doesn't normally come.

045 C.A: **But you have never asked him?**

046 BP13: Yes.



047 C.A: **Why?**

048 BP13: I do wait for him to come to our house so that I can inform him of what I want him to buy for me but I have never asked him for that.

049 C.A: **Now what makes you happy? //**

050 BP13: What makes me happy is that my mother has involved me into a group/ this group and I'm a member, now I'm happy because I

 Cultural Traditions impact

 Happiness
 WVP

	learn more. Also when my mother or father buys me something I lack, I become happy.	
051	C.A: (Coughing) now what are your memories as a child?	☀ Being 'other'
052	BP13: My memory is that when I complete my education, I get a good job. Sometimes I do think to tell my friends to change their behaviours.	☀ Importance of education
053	C.A: Now in your community, how is your life different from the life of other children?	☀ Abuse and vulnerability
054	BP13: There are some children in our community who are orphans, some are being mistreated and me I'm not mistreated in our house and so we are different.	☀ Orphanhood
055	C.A: Is there anybody you are taking care of or anybody you assist?	☀ Caring for community elders ☀ Personal care
056	BP13: The person I'm caring for is just the old grandmother in our village whom I had told you before and my maternal grandmother and my mother.	
057	C.A: How do you assist them?	
058	BP13: Sometimes when my mother is sick, I cook for her because my younger sister cannot cook. Sometimes I prepare for her porridge to take. After school, I give her what she wants; boil for her water to bathe in case my father is not within. If my father is around, he washes her. Sometimes I wash her legs and then we chat.	☀ Disease and family background ☀ I ☀ Young caregiving and duties
059	C.A: Do you normally wash all her clothes?	
060	BP13: I normally wash the easy ones but some I don't know how to wash.	
061	C.A: Now who wash the rest?	
062	BP13: She normally washes them alone because my father doesn't wash clothes.	☀ Cultural Traditions impact
063	C.A: Now she washes them while sick/	
064	BP13: No she just keeps them and washes them later when she recovers.	
065	C.A: Does she become sick very often?	
066	BP13: If sometimes.....When I light fire in the house and she inhales the smoke, she suffocates. It normally happens to her during the rainy season when its cold.	☀ Health problems
067	C.A: Now which kind of disease is it?	
068	BP13: I think it is asthma.	
069	C.A: Now how do you assist at home?	
070	BP13: If I went home with a certain brother of	☀ Young caregiving and duties

- mine, we look after cattle, fetch water, clearing the compound, when it is ploughing season, we plough, weed and harvest. Sometimes we fetch firewood in a nearby bush and take to the grandmother. Sometimes when the grandmother is away, I cook for children.
- 071 **C.A: Where is your home?**
- 072 **BP13:** After reaching Imbo Nyamonye then you continue with the journey upto Majengo. There is a path, you branch to that path after reaching Majengo school, Secondary is opposite Primary and the path is between them. You just continue with the path until you see our home (Another child is coughing)
- 073 **C.A: Which kind of duties do children perform?**
- 074 **BP13:** They can wash plates.
- 075 **C.A: I mean these children taking care of the ill and the old, how is their life?**
- 076 **BP13:** They are working too much and yet with her, she knows that she is caring. So you may say that so and so is overworked and ye the/she volunteer and knows that he/she is assisting.
- 077 **C.A: But what kind of duties does children do for the old and the ill?**
- 078 **BP13:** Washing him/her, cooking for him/her, feeding her and washing her clothes and in case she has a child; you take care of the child and feed him/her.
- 079 **C.A: Another one?**
- 080 **BP13:** If he/she is in hospital, you take to him/her food daily and water for bathing. Sometimes you can read for him/her bible so that she can recover.
- 081 **C.A: Now these children caring for the sick and the old, who give them, support or where do they get the support from?**
- 082 **BP13:** Maybe their relatives. Like me when I'm taking care of my mother, there is aunt of mine who normally comes and assists me in caring for her. There is also uncle of mine who normally comes once and gives us money to buy for her what she wants.
- 083 **C.A: What about father?**

☀ Challenge
 ☀ Felt need to act
 ☀ Self perception

☀ Caring for children/siblings
 ☀ Personal care

☀ Spiritual Support

☀ Family support

084 BP13: If my father is sick he.....

085 C.A: **No, by the time your mother is sick that you are supported by other people, what about him?**

086 BP13: He just buy drugs but do not take her to the hospital, she waits for her to go alone. At that time he jut relaxed in my step mother's house and only comes when the child is sick and buy him drugs and then he goes back. He doesn't want to know the child's condition and only come back when they recover.

087 C.A: **Now, why doesn't he want to take her to the hospital?**

088 BP13: He thinks that you will ask him for money. Even if he has money and you ask him for, he will tell you that the money belongs to school. Now my mother doesn't normally ask him for money because even if you request him, he won't give you. Sometimes she used to cry if she asked him for money and he refused.

089 C.A: **He doesn't normally provide?**

090 BP13: Yes.

091 C.A: **Does he do so now?**

092 BP13: Sometimes..... He wanted to go to Siaya for a seminar. Now he had money and went to West-end hotel and took beer with some ladies who organized with some men to take his phone and his money. Now when he came back, he told us so.

093 C.A: **What did he told you?**

094 BP13: He told us that he doesn't have money because his money is lost. He then went to seminar and did not tell us anything else.

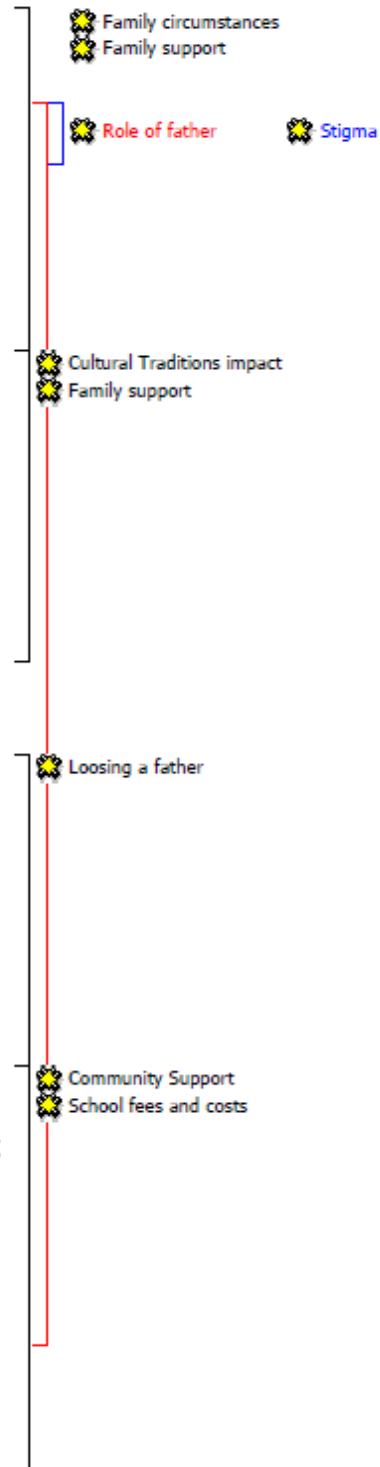
095 C.A: **Now that is why he doesn't normally take mother to the hospital when sick?**

096 BP13: Sometimes he can get money and do nothing with it. Sometimes we can be sent from school because we lack money and if my mother doesn't have, she asks the neighbour. With him he just goes to school but I can't follow him there to give me money.


097 C.A: **Is he a teacher?**

098 BP13: Yes.

099 C.A: **Now he doesn't pay for you?**




- 100 BP13: Yes.
- 101 C.A: **Now what does he normally do for you?**
- 102 BP13: He just normally pays mock and educational fees and also gives my mother money for charcoal and flour only. The rest like clothes he has never bought.
- 103 C.A: **Now what makes the ill and the old to be happy? // what makes them happy?**
- 104 BP13: Makes him/her happy?
- 105 C.A: **Yes, the ill or the old.**
- 106 BP13: If you take good care of him/her, he/she became happy, even if she is a grandmother, she knows that you love her now that can make them happy.
- 107 C.A: **Now what do you normally hope to happen to you in future? //**
- 108 B13: I hope to go to Secondary and University and get a good job so that I can support my relatives together with my family if God helps me.
- 109 C.A: **A good job like which one?**
- 110 BP13: Like a police officer or Commissioner//
- 111 C.A: **Thanks.**
- 112
- 113

 Dreams and aspirations


 Hope

01 **NAME:** L5
 02 **VILLAGE:** MAGO
 03 **DATE:** 17/02/08





04
 05 **HOW I'VE BEEN CARING FOR MY MOTHER.**

 Sick parents/guardians




06
 07 I cared for my mother twice. The first caring I did to my brother's wife and the second one was for my mother in the year 2003. I was 11yrs in class four and because I was the one with her, I had to care for her because she could not even stand. This forced me to leave school for about two weeks so that I could care for her. Because my mother was the source of everything, I didn't know what to do.

 Missing school

08
 09 Since she could not even stand up, I looked into ways by which I could get food. I used to fetch firewood, take to the market to sell and then buy food. I used to wash her and then put on clean clothes for her. When my brother saw this, he called a doctor who came and treated her.



 Child-headed household
 Family support
 Personal care
 Income generation

10
 11 The doctor found that she was lacking water in her body so she was added water and treated properly until she recovered after some months. In the month of July, she again became sick. This was serious and we knew that she was going to die. This forces me to leave school again so that I could take care of her. Now my mother was just bed ridden.

 Disease and family background
 HIV/AIDS
 Missing school

12
 13 I also could only do the things I was doing before to earn a living and to assist my mother. I was fetching firewood to take to the market for sale is when we could get food. We continued that way until I one day decided to take her on a bicycle to the hospital (Ratuoro dispensary). Now I

 Income generation  Young caregiving and duties

 Lack of support
 Poverty

was just taking her to the hospital so that she could recover. When I took her the second time, she was told to go to Siaya District hospital but since there was no money, we just stayed with her. My brother was not taking any action because he was overpowered by the wife and so he could only listen to the wife.

14

15 Now one day my brother came into the house and saw how my mother was. The following day, he came with a vehicle and took my mother to the hospital. Since there was nobody to take care of her in the hospital, I volunteered to do so and my brother took the two of my siblings to his house.

16



17 We then went to Siaya District hospital where I then took care of her. Now she was treated and given some solid drugs. We stayed there for about a week preparing food for her and bathing her. My brother also used to come there bring food for us. When my mother recovered, they wrote for us some drugs which my mother should take monthly and getting them from Ratuoro dispensary. When then came back home after my mother had recovered.


18

19 HOW I CARED FOR MY 20 BROTHER'S WIFE.


20

21 My brother's wife was sick and her co-wife had a newly born baby, my mother could not do it because she was weak and my sister also had a baby. Now there was no alternative. And because there was no woman in the village who volunteered to care for her, she was being treated at home. Because my brother also had a job and could not leave the job, I was

 Family support
 Sharing

 Routes to care

told to go with her to the hospital. We stayed in the hospital for a period of 3months not going to school. I was the one washing her, changing her and by then we were at Bondo District hospital. Because the doctors from Bondo did not get any disease from her, she was transferred to Kisumu for X-ray. So I went and telephoned my brother at around 10.00a.m and he told me that he is coming immediately. After a short time, he came and we both went to Kisumu. Immediately we reached Kisumu, my brother's wife passed away. We left the body in mortuary and then we went back home. Later on she was brought home then buried.

 Personal care

22

23

Proposal Name: YOUNG FARMERS CLUB / KALE GROWING

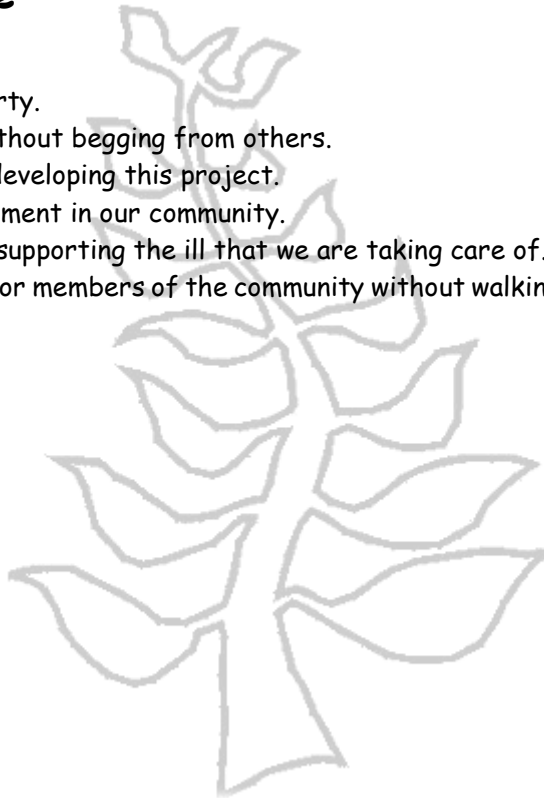
Location/Area: OCHUOGA VILLAGE

Submitted by: MBILI YOUNG CARERS

Amount Required: SHS. 12,980.

Key words tree

- To prevent poverty.
- To get money without begging from others.
- To get away of developing this project.
- To bring development in our community.
- To get a way of supporting the ill that we are taking care of.
- To supply kales for members of the community without walking along distance looking for vegetables.



For WVP office use only:

Proposal Accepted on:

Signature Date

Signature Date

Background

What is the problem and how will this project change that?

- Our need is to get education by getting what we don't have through the project.
- To get whatever we are lacking while caring for the ill.
- To get money for starting another project without asking from others.
- We think we can help this by planting and taking good care of the vegetables.

Project Description

Provide a description for the proposed activities.

Kale growing.

- We are planning to get vegetable seeds.
- We are planning to get barbed wire to fence the area.
- We need to get pesticide to spray the vegetable.
- We need barbed nails for fencing.
- We need things like water cans.
- We need fork jembes.

Aims of the project

Give a brief outline of what the project will aim to achieve when it is done.

- After selling the vegetables, we can buy some three goats which will give birth to others.
- We think we shall get what we want like school materials.
- We think this project will make us know how to cultivate and we will know how to grow vegetables.
- We think we can get uniforms for Bar puoyo young carers we are printed so that we can wear when coming to programme or when we are going to meet other people.
- We think that through this project, we can be professors who can educate others on kales growing.

Project Outline

Provide an outline of the expected results.

- We think that this project will succeed and get enough money to expand it.
- We will get money through it.
- We will get whatever we lack through it.
- We are planning that the vegetables we shall get can be sold to get money so that we can help our members who have different problems which they cannot solve by themselves.

Project Management

Who is involved in the project and what are their roles?

- John	-Chairman	They guide the meetings
- Carolyne	-Ass. Chairman.	
- Jane	-Secretary.	
- Michael	-Ass. Secretary.	They write the minutes.
- Francis	-Treasurer.	
- Carren	-Treasurer.	They keep the money got from the project.
- Millicent	-Ear/Eye	
- Geoffrey	-Marketing dept.	
- Kevin	-Marketing dept.	Looking for market for goods to be sold.
- Everline	-Marketing dept.	
- Mercy	-Member.	
- Lucy	-Member	
- Joyce	-Member	
- Roseline	-Member	
- Syprose	-Coordinator	

Tasks and Milestones

provide a list and brief description of all project milestones and when they are expected to be achieved during the project.

1. We will cultivate the land.

2. Plant the seeds in nursery bed.

3. Watering the seedlings in the nursery bed.

4. We will transfer the seedlings from nursery bed to seedbed.

5. Weeding and watering vegetables.
-Spraying with chemicals.

6. Selling vegetables to small scale sellers and looking for market for the products.



Financials

At an early stage, contact WVP in order to ensure that you identify correctly all activity costs.

Resources sought from WVP

Project:	
Items	Cost (Ksh)
Seeds (2 tins)	120/=
4 water cans @350	1,400/=
2 bottles of pesticides	500/=
4 roles of barbed wire	10,000/=
Nails (6kg)	600/=
Fork jembers	360/=
TOTAL COST	12,980/=

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