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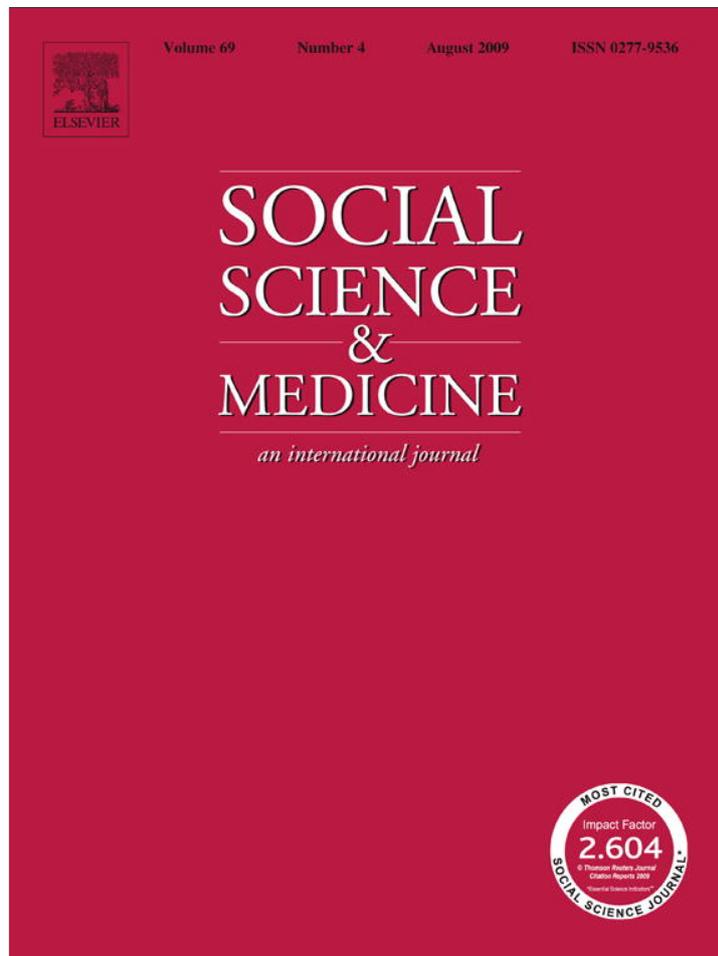
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Young carers as social actors: Coping strategies of children caring for ailing or ageing guardians in Western Kenya

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ABSTRACT

There is a vast body of research on the impact of HIV/AIDS on children, but little which acknowledges the role of children in providing care and support for ailing parents or ageing guardians. There has been a tendency to downplay the active role and agency of young carers, with young carers often represented as victims of damaging circumstances that compromise their psychosocial well-being. To counter-balance this tendency, and to develop the critical trend that views children as social actors, we explore how young carers cope with challenging circumstances, often with skill and ingenuity, drawing on data collected in Western Kenya in 2007. Forty-eight young carers (aged 11–17) used photography and drawing to provide accounts of their coping strategies. They described 240 of the resulting photographs and drawings in writing. In addition, 34 individual interviews and 2 group discussions were conducted with children to explore the findings further and 10 individual interviews with local adults were conducted to elucidate the dynamics between adults and children. Our data revealed that young carers cope by mobilising social support, engaging in income generating activities and constructing positive social identities around their caring roles. We conclude that children's ability to cope is determined by the extent to which they are able to participate in their community and negotiate support from it.

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Introduction

"Caregiving has changed my life to cope with adverse 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 (age 14)

This paper investigates the coping strategies developed by children caring for ailing and ageing guardians in HIV/AIDS-affected households. Drawing on research in Western Kenya, it advances the view of children as competent social actors rather than damaged victims, highlighting the skill and ingenuity many children show in mobilising support, generating income and constructing positive identities in conditions of tremendous adversity, poverty and stigma.

Many African children endure stressful life events as their parents fall ill to tropical and infectious diseases, assuming significant caring and head-of-household responsibilities, often in contexts of extreme poverty (Bauman et al., 2006; Robson, 2000; Robson, Ansell, Huber, Gould, & van Blerk, 2006). AIDS has increased the risk and vulnerability of children (Foster, Levine, &

Williamson, 2005) and brought young caregiving (Robson, 2000; Robson et al., 2006) and child-headed households (Foster, Makufa, Drew, & Kralovec, 1997; Richter & Desmond, 2008; Ruiz-Casares, 2007) in Africa into focus.

Echoing the more long-standing body of young carers research in the UK (Aldridge & Becker, 1993; Cree, 2003; Dearden & Becker, 2000), most research on young carers in Africa has attended to their risks and vulnerabilities. These include disruption of schooling, loss of friends and isolation, the difficulties of looking after an ailing person and the wider household and trauma resulting from caring and bereavement (Bauman et al., 2006; Robson, 2001; Robson et al., 2006). Similarly, research on child-headed households focuses on their vulnerability to abuse (Ruiz-Casares, 2007), poor sense of self-worth, unresolved grief, lack of long-term goals and poor internal locus of control (Donald & Clacherty, 2005) and their lack of social support (Thurman et al., 2008). It is therefore unsurprising that the phenomenon of young caregiving has alarmed many academics and mental health professionals, with studies exploring the negative psychological impacts of being a young carer (Bauman et al., 2006) or a child household head (Boris et al., 2008).

Despite the many risks and stressors associated with disease and poverty, counterintuitive accounts by children, such as the one cited above, call for a greater understanding of the strategies

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constructed by caregiving children to cope with adversity. Some attention has already been given to the potential benefits of young caregiving. These include learning new skills, developing close and loving relationships with the person that is cared for and growing up as a mature and responsible person (Donald & Clacherty, 2005; Robson et al., 2006). As these risks and benefits are mediated by children's local communities, which may support or hinder the coping of young carers, it is vital to explore this level of analysis.

Towards a social psychology of coping

Historically, most theories of coping focus on the individual, seeking to generate universal and generalisable conceptualisations of coping processes (Garmezy & Rutter, 1983; Lazarus, 1966). More recent research shows 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 (Ungar, 2008). Reflecting Qvortrup's (1994) conceptualisation of children as active co-constructors of their social worlds, we seek to contribute to a social psychology of coping by mapping out how young carers cope through the way in which they engage with what Rutter (1979) refers to as 'protective factors' (e.g. social support, household cohesion, personal attributes) within their communities. Echoing Panter-Brick (2002), we therefore believe that children's ability to cope is a reflection of their agency and active engagement with their social environment and not only a reflection of the availability of protective factors.

Resilience refers to peoples' positive capacity to cope with adversity, and provides a useful conceptual backdrop for our research. The concept is increasingly used in research on children in Africa (Daniel, Apila, Bjorgo, & Lie, 2007; Evans, 2005; Fjermestad, Kvestad, Daniel, & Lie, 2008) to counter-balance the tendency to focus on their vulnerability. Early definitions of resilience defined it in relatively static and individualistic terms, as a fixed characteristic of individual children (e.g. access to social support) (Olsson, Bond, Burns, Vella-Brodrick, & Sawyer, 2003). However, on the basis of cross-cultural resilience studies, Ungar (2008:225) argues 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". It is this conceptualisation of resilience that frames our study. In line with Ungar's (2008) emphasis on the cultural and contextual specificity of resilience, we argue that a social psychology of coping is necessary 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.

Although this paper is framed within the HIV/AIDS literature, we acknowledge the large numbers of children affected by other diseases and poverty more generally, and use the term 'young carers' to refer to children under the age of 18 who provide nursing care and support for sick, disabled or elderly relatives or guardians

(regardless of HIV status) on a regular basis and play a key role in sustaining the household.

Methodology

The research question guiding this phenomenological study is: What strategies do children construct for coping with the demands of disease and poverty? Our study was granted ethical clearance by Research Ethics Committees of the London School of Economics and the Department of Social Services in Kenya. We have used pseudonyms to protect participant identity.

Study setup and sampling

The study was conducted in the rural district of Bondo alongside Lake Victoria. Bondo was chosen because of its high HIV prevalence rate, estimated at 13.7%, twice the national average (NACC, 2005). The district is poor. Fifty-eight percent of its inhabitants live in absolute poverty; 79% depend on agriculture and subsistence farming, leaving them vulnerable to recurrent droughts and infertile soil (GOK, 2002). Research informants were recruited from two communities. As there was no known local definition of 'young carers', children who did more than 25 hours of work, including caring for an adult, per week were purposefully recruited by local community guides. Guides were encouraged to identify children with diverse experiences (e.g. caring for sick parents, relatives, siblings or elderly guardians – past and/or present) with equal numbers of boys and girls.

Table 1 outlines the data collection procedure. Twenty-four children aged between 11 and 17 were selected from each community (total of 48 children; 20 boys and 28 girls). This age range was chosen because children younger than 11 are likely to be cared for by older children and less likely to provide significant care. Children of 11 and above are believed to think more abstractly and reflectively, and make better sense of the information and meanings available to them (Piaget, 1929). In addition, 10 adults (including 8 lay people and 2 social development professionals) were recruited from the 2 communities to explore adults' conceptions of childhood and their perspectives on young caregiving.

Following Lewin (1948), this action research project involved children in data collection, and their observations were immediately translated into action through cash grants from a local NGO (WVP Kenya). Drawing on the community-based capital cash transfer method (Skovdal, Mwasijaji, Morrison, & Tomkins, 2008), the NGO spearheaded the development of two Youth Clubs (one in each community) in consultation with our young carer informants. Involvement in this study rendered young carers eligible for club membership, providing them with opportunities to get together with peers in similar circumstances and act to address common needs identified through their participation in this study. With the cash grants (equivalent to €50 per child) children collectively set up income generating activities (such as selling maize and poultry farming) to support themselves and their guardians. The clubs continue to be facilitated and supported by social workers from WVP Kenya. This action research project is a response to the ethical dilemma, recently noted by Nyambedha (2008) in a similar setting

Table 1
Data collection procedure.

Steps	Date	Who	N	Methods	Sampling
1	June/July 2007	Young carers	48	Photovoice and draw-and-write technique	Recruited purposively through local community guides
2	July/August 2007	Young carers	24	In-depth interviews	Selected to represent diversity of responses on photovoice
3	September/October 2007	Young carers	33	Group discussions	All participating children invited
4	September/October 2007	Adults	10	In-depth interviews	Purposively to include lay people and social development professionals

These reflections were shared by children in a workshop designed to help them collectively develop an action plan for tackling some of the problems they had identified.

As noted in Table 1, 24 further individual interviews and two group discussions were conducted with children and 10 individual interviews with adults for further understandings of children's experiences. Individual interviews and group discussions were conducted using an unstructured topic guide which explored the positive and negative aspects of caring, the social meaning participants attached to caring, the type of support they needed, and the mechanisms of social support available to them. These questions generated information about local perceptions of childhood and young caregiving from different sources (adults/children) and in different settings (individual/groups). Data were collected by two local research assistants (one male and one female, both aged 24 and staff of the NGO) in the local Dhluo language and recorded, transcribed and translated into English.

Data analysis

Interviews, group discussions and written narratives were coded and analysed in Atlas.Ti using thematic networks analysis (Attride-Stirling, 2001). Attride-Stirling outlines six stages for interrogating explicit statements to uncover implicit social meanings and coping strategies. We discuss each of these stages below.

The outcome of this analysis is presented in Table 2. An initial reading of the data provided descriptive accounts of the topics raised by our informants, called 'codes' (step 1). Themes were abstracted from the coded text segments (step 2). A process of progressive examination and refinement of themes served to cluster them into groupings called Organising Themes, which were further refined and 'reduced' into four Global Themes (step 3). Concurrently, differences and commonalities with regard to gender, location, caring arrangements and age groups (11–14 and 15–17) were explored.

The first global theme pulled together background information about the context and conditions under which children engaged in caring roles, and their needs and difficulties. In our discussion below, we use material categorised under this theme to frame and contextualise the three coping processes that constitute the remaining three global themes.

These three global themes constitute the over-arching 'thematic network' depicting our key findings (see Fig. 1) – namely that child carers meet the demands of their everyday lives through the three coping strategies of 'mobilising social support and resources', 'engaging in work and income generation activities' and 'constructing positive identities'. In Ungar's terms, these strategies are evidence of children's resilience in this particular setting. These three themes capture the different ways in which children actively construct and negotiate the resources and representations they use to tackle the demands of everyday survival and caring in adverse conditions.

Having mapped out this thematic network, and the associated organising themes, we returned to the original data to refine our understanding of children's coping strategies through further detailed re-examination of the data in the light of this emerging framework of analysis (step 4 of Attride-Stirling's approach). In our findings section below, we describe and elaborate on these three coping strategies (step 5), explicitly relating our findings to our research question (step 6).

Findings

Each child's circumstances were uniquely influenced by their particular ecological context, including the composition and socioeconomic status of their households. Some children were sole

carers, others had support from a parent or siblings. These unique circumstances determined whom they cared for, what caregiving responsibilities they had and the duration and frequency of caring. Responsibilities included cooking, cleaning, washing clothes and generating income – responsibilities which 'non-caring' children in this context also often have. However, young carers also had additional nursing responsibilities, including administering drugs, spoon feeding, cleaning bodies and bedsores and providing emotional support. While some duties were constant, nursing duties could fluctuate. Although 'non-caring' children in this setting often contribute significantly to their households as well, these duties tend to be seen as part of their socialisation, rather than being driven by need.

All the participating children were in school, however they had all experienced some disruption as a result of their caregiving duties. Most young caregivers had cared for a number of people over time, including elderly relatives, parents, siblings or community members. Although slightly more girls reported doing nursing responsibilities and slightly more boys reported doing income generating activities, only few households could afford to live up to local gender roles. One woman described this change: "It was against Luo culture for a boy to cook, but today it has changed, they cook and do domestic duties. If the first-born are boys and the parent is sick, it will be the boys that cook and not the younger girl". This not only reflects a re-shuffling of resources within the household according to circumstances, but also a strategy to socialise boys to do such duties in preparation for the possible premature death of their own spouse one day: "If you don't teach him to cook, his wife may die leaving him with the children. Today you cannot know who will die first".

Unsurprisingly, the young carers referred to various challenges arising from their caring situations. They spoke not only of interrupted education, but also of inadequate access to nutritious food, limited time for friends, and time-consuming income generating activities. As they typically lived in households with adults unable to work, they had access to fewer resources than children from other households and were often noticeably poorer. This brought the added struggle of poverty stigma, a burden articulated by almost all the young carers as they described their needs relative to those of other children. But how did the children attempt to cope with all these challenges?

Mobilising social support and resources

One source of support was the extended and immediate family, with male relatives often contributing money and female relatives more often visiting households and supporting them with food and nursing care. It was often the oldest child living at home who took the role of head-of-household responsibilities, supported by younger siblings who did lighter duties (such as cooking, fetching water and firewood). Although some responsibilities were typical for boys or girls, in times of need, gender appeared to play a less important role, as stated above. 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". Once the first-born child moved away from home, the second born sibling typically took over the caring responsibilities, but with continued support from the older sibling who could send back money or food. However, not all caregiving children had an older sibling who could send money. They relied on the support of extended family. While many children did benefit from their relatives, the stigma associated with AIDS sometimes impeded this support:

"I was left alone with my sick father and he was begging me not to leave him alone. I was told to go and find my mother for support. When I reached my uncle's place where she was, I was

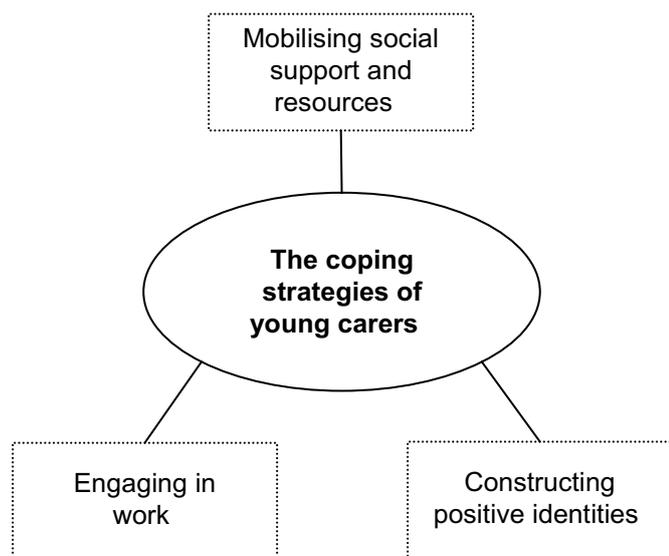


Fig. 1. Summary of thematic network.

chased away. This made me really sad. When I got back to my father he was at his last breaths.” Martin (age 14)

At the other extreme, children may be removed from their home by aunts and uncles who subsequently take over caring responsibilities – this happened to one child in our study. Children could also negotiate support from community members, who often acknowledged the difficulties of young carers, helping them to buy drugs for their parents, school materials, clothes and food.

“If a child lives with a sick or old and is having difficulties, I can buy the child clothes.” Female Adult Community Member

“If I have no food, I get it from the neighbours,” Richard (age 12)

This strong community ethic which often made support available to children during times of hardship also shaped the way children themselves articulated a strong ethic of responsibility to care for those in need of support. This was well articulated by 15-year-old Carlyne:

“This woman helps those children who cannot get certain things and those who are old and sick. This photo of her shows that we should all join hands and help the old and the sick.” Carlyne (age 15)

Much support from community members was channelled through various grassroot groups, typically established by widows to support orphans and vulnerable children through providing meals. However, community support was not available to all the children and could be constrained by additional challenges such as drought. This was expressed by 15-year-old Janet who described a photo of her ailing mother preparing leaves which Janet had picked from the bush:

“This photo reminds me of how we can get through difficult times with food shortages and when there is nobody to welcome you for dinner.” Janet (age 15)

Community and grassroot groups fill the social landscape in Bondo and our study suggested these groups can play an important role in helping children and other vulnerable community members. In addition to many adult-run groups, some children were themselves able to run groups and clubs aimed at helping one another, with adult guidance. Friendship groups were also of great importance as described by 15-year-old Ursula:

“I want to talk about my friends because we 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 also helped me fetching water and firewood. 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.” Ursula (age 15)

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 were described as judgemental and excluding, schools were also often identified as places that acknowledged the challenges faced by many caring children and showed them flexibility and support:

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

Churches were also mentioned by many children as sources of food and emotional support. The role of faith in helping these 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.

“By helping the needy we are also blessed by God.” Claire (age 17)

“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.” Carrie (age 14)

This sub-section has illustrated some of the ways in which young carers actively mobilised resources from their social environment in coping with vicissitudes. Immediate family members tended to work together in providing care and support, and extended family members could provide resources and extra support when required. Neighbours, schools and community groups, some initiated by the children themselves, could also be significant coping resources. However, a minority of children did not manage to mobilise supportive social resources, especially in times of drought or in highly stigmatised homesteads. It was when such social resources were limited that these children actively and competently engaged in income generating activities that helped sustain their livelihoods.

Engaging in work and income generating activities

Aside from providing nursing care to ailing or ageing household members, the absence of productive and working adults meant that some young carers in our study had the added responsibility of earning money and growing food. While responsibilities differed according to the circumstances of each household, all the children in our study contributed significantly to wider household subsistence efforts – generally as part of a collective effort, with only a few doing this single-handedly. To cope with the lack of resources and food, boys and girls engaged 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 diversified their diet. It also enabled them to purchase medicines and provide nutritious food for their ailing guardians.

“When we have chickens, we can sell them and that money can solve some of our problems. This photo shows chickens that are helping me in my life as they provide eggs which I can provide as food to help those who are sick. Sick people require a diverse diet and cannot only eat vegetables – and these chickens lay nutritious eggs.” Ursula (age 15)

Cows, goats and chickens served not only as important lifelines in sustaining the daily living of most of the children, but also gave some of them hope for a brighter future when their animals reproduced and served as an insurance and asset. Those children fortunate to have livestock or generous fruit trees spoke of 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.” Jackie (age 12)

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:

“When my father was sick I had a vegetable garden which I used to cultivate and sell produce from to get money for drugs and food for my father.” Jack (age 16)

Activities engaged in by Jack, Ursula and Jackie illustrated their competence and resilience. At a young age, these children had significant responsibilities, including deciding 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. A few girls also provided sewing services on weekends to earn extra money. Some commented that these activities, combined with caring responsibilities, took up a great deal of time and impacted negatively on their education. Nevertheless, although most of the children were concerned about missing school, some showed tremendous resilience in faring well in school despite their other life challenges:

“In September when school reopened, I missed school as I stayed at home caring for my sister. When I joined school again only four weeks before the exam, the teacher encouraged me to study. I worked hard on my studies, prayed and managed to be position 9 out of 48. I managed to perform well despite only studying for 4 weeks out of 14 weeks in the term.” Catherine (age 14)

The involvement of all our 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 differed according to the availability of social resources. Those young carers who were the sole income

generators in their households had to drop out of school for periods to cope with the demands of sustaining their households.

Constructing positive identities

Nearly all the children in our study depicted their role as care-givers in some positive light. Local cultural understandings of duty and childhood often served as useful symbolic resources in constructing positive carer identities. Sarah, aged 15, spoke of how children are viewed as ‘helpers’ in her local community:

“The duty of a child is to help parents. A child is called a helper because when a parent or guardian want something which they are unable to go and get, they will send the child to go and get it.” Sarah (age 15)

In the light of the local perception of a ‘good’ child as being helpful in the home, young carers were by implication exceptionally good children. An acknowledgement of the value of their caring duties by adults supported this perception. Children valued this positive recognition very highly.

“All the caring I have done makes me happy because the villagers love me seriously since I don't do bad things in the community. I like helping people.” Simon (age 13).

Furthermore, many children commented that the very activity of caring served to distinguish and distance them from non-carer children, who were depicted as lacking young carers' work ethic and their willingness to take on menial but significant responsibilities.

“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 (age 17)

For a few children, caring was regarded 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. In the process of developing a caring identity, many young carers said these skills were lacking in non-caring children. As 12-year-old Marina commented: “I become strong; I don't become a weak child”. Sometimes, children even found pleasure and pride in their responsibilities.

Drawing on representations of childhood as a time of duty and service, these more positive perceptions and meanings helped many children to view caring as a challenge and opportunity for personal growth and socially valued service, rather than a hindrance or obstacle in their lives. Although most of our adult informants also supported this notion of childhood as a period of duty and service (and part of the child's socialisation), a few adults felt young caregiving was inappropriate – a view also adopted by some children.

“It is a really difficult situation for them [young carers], and these children will not develop well, even if they are supported – they are given a responsibility that is too heavy for them to manage.” Female Adult Community Member 2

While most children, particularly the younger age group (11–14), were able to ascribe positive meanings to caring and construct a positive identity around it, there were a minority, particularly from the older age group (15–17), who regarded caring as ‘an enemy’,

emphasising the negative effects of caregiving on school attendance:

“Our mother had been sick for a while and I was the one caring for her. Sometimes she was so sick that I had to take her to the hospital and it forced me to miss school. I found it very difficult because she was also the one who was taking care of me, but I left school and decided not to return until she was feeling better. I haven’t found anything good about this experience, it has been total suffering and spoiled my education.” Austine (age 15)

In rare cases, the emotional cost of caregiving did influence children’s own sense of well-being, leading them to construct an entirely negative identity in relation to their caring responsibilities. One such child was 14-year-old Benjamin who cared for his mentally ill mother and who saw caring as a punishment, viewing himself as trapped in a highly negative situation:

“My mother is so annoying and challenging that nobody else can take care of her. I have other brothers, but they have given up on caring for her. I sometimes feel that I should not have been born. For this reason, I curse the day I was born, like I curse the job of caring.” Benjamin (age 14)

While a minority of children ascribed either entirely positive or entirely negative meanings to their caregiving experiences, most of them attached mixed meanings. Negative meanings were often fuelled by a lack of social support and poverty (as with Benjamin). 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 impacts of caring on education and school attendance were the greatest concern for many of these children. Their regret of their interrupted education was at the root of almost all the negative meanings informants ascribed to their caregiving roles.

Discussion

Framed by our interest in resilience as well as vulnerability, and by our commitment to viewing children as competent social actors rather than passive victims of detrimental circumstance, this paper has sought to highlight the strategies developed by children to negotiate the challenges of young caregiving. However, as is the case with all small-scale exploratory research studies, care needs to be taken in accepting the trends and relationships outlined in this paper, particularly due to the small sample size and the specific location of the study. The children were purposively sampled through local community guides whose recruitment techniques could have biased the study. Problems such as recall bias (e.g. inaccurate memories of their caring experiences), or expectations of assistance from researchers, might also have framed the accounts given by informants. While we believe our research 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, we acknowledge that situating work on young carers within the AIDS literature runs the risk of an undue focus on children directly affected by AIDS, at the expense of many equally vulnerable children affected by poverty and other diseases (Meintjes & Giese, 2006).

Notwithstanding these limitations, we believe our findings provide valuable support for our claim that children are often able to draw on a range of coping strategies and manage their difficult circumstances extraordinarily well. Our 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. This resonates with findings from Ethiopia (Abebe & Aase, 2007), Tanzania (Porter, 1996) and South Africa (Donald & Clacherty, 2005). We have highlighted that one caregiving experience often leads to another, making some children’s experience of AIDS long term and cumulative – an observation also made in South Africa (Hosegood, Preston-Whyte, Busza, Moitse, & Timaeus, 2007). Resonating with findings by Ruiz-Casares (2007) in Namibia, the lack of social resources within many households leaves gender roles increasingly fluid. 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 – indicating how the AIDS epidemic can change local understandings of childhood and the socialisation of children (Kesby, Gwanzura-Ottemoller, & Chizororo, 2006).

The social resources available to young people have a significant impact on their coping and resilience. Within the immediate family, siblings share responsibilities. From the extended family, aunts and other female family members may come and help children with the nursing and household management aspects of caring, while uncles and grandfathers may send money or provide children with land to cultivate. Support from community members and groups also remains critical to coping. Women and community groups were frequently mentioned, but of particular interest is our finding that children themselves are also able to mobilise very effective friendship groups and networks with other orphaned and vulnerable children – a capacity also identified by Donald and Clacherty (2005) in South Africa. In agreement with findings from Rwanda (Thurman et al., 2008), it is also evident from our study that poverty and AIDS stigma may limit the availability of community support.

Many children in our 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 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. In our study, local representations of childhood were found to facilitate this process – a process that also involved an ‘othering’ of non-carers as lacking in work ethic. While we distance ourselves from this view, it remains an ingredient in the construction of identities among our informants. Although childhood is commonly perceived to be a time of duty and service, some adults find nursing duties inappropriate for children – highlighting the dynamic and multiple nature of representations of childhood within this context. Such dynamic conceptions of childhood and identity potentially provide a starting resource for support agencies seeking to promote health-enabling social environments in which young people can revive and negotiate positive caring identities, build on existing knowledge and skills and recognise and affirm their strengths and resources – all factors that can contribute to strengthening local community responses to AIDS (Campbell, Nair, & Maimane, 2007). This was the intention of the youth clubs that were established as part of our action research study.

It is clear that constructions of childhood do matter in debates about how best to support young carers in adverse social settings.

It is critical that NGO workers and researchers working with young carers problematise the tendency to universalise what are in fact their own very culturally specific assumptions about what should constitute a 'normal' childhood, and their tendency to implicitly or explicitly depict those who do not have this type of childhood as inherently problematic, or to describe them in the language of poor mental health. Echoing Kesby et al. (2006:186), "If the real needs of children in the global south are to be met, there is a need to conceptualise 'other childhoods' as they are and not in terms of what they are not".

We have shown that many young caregivers have the ability to actively construct effective coping strategies and to mobilise the social resources available to them, making it appropriate to view many of them as competent social actors. Children not only cope with their own circumstances, but also help communities cope with the devastating effects of AIDS (Ansell & Blerk, 2004; Kuhanen, Shemeikka, Notkola, & Nghixulifwa, 2008). We suggest service delivery organisations take heed of this finding 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. One way to do so would be to mobilise and provide community organisations with the resources required for them to provide young carers with adequate and locally appropriate support (Skovdal et al., 2008).

Conclusion

Drawing on action research in Western Kenya – and framing our discussion within wider debates about the processes of coping and resilience, and the view of children as competent social actors – we have illustrated how many children in our study manage to cope with the challenges of caring for ailing adults in challenging conditions. Our data support our reservations about the tendency of some researchers to view child caregiving solely as a source of risk and adversity. Against this conception we have highlighted the skills shown by many children in constructing positive identities, mobilising support and engaging in successful income generation activities. We 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 and valued life skills.

The trends emerging from our study suggest children's coping is determined by the extent to which they are able to participate in community life and negotiate support from it. We conclude that the extent to which a child is able to cope depends on (1) the on-going negotiation between individual and community which shapes a person's identity, and their 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) children's different abilities to negotiate community support. This social psychology of coping opens up a new level of analysis, one that explores community-based activities and the impact of community relations on the coping of individuals. Given that factors determining children's agency are likely to differ across space and time, future research and intervention need to consider the local context of young caregiving – and to identify and build on children's strengths and resilience, with the goal of better understanding and supporting the coping processes we have illustrated above.

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