

# **A census report of orphaned and vulnerable children in two South African communities**

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## EXECUTIVE SUMMARY



The Human Sciences Research Council (HSRC) together with its partners within the Southern African Development Community (SADC) region have been commissioned by the WK Kellogg Foundation (WKKF) to develop and implement a five-year intervention project on orphans and vulnerable children (OVC), as well as families and households coping with an increased burden of care for affected children in Botswana, South Africa and Zimbabwe.

There are currently no reliable statistics available about the numbers of OVC found in any district of South Africa. This is also true for the two study sites of Kopanong Municipality in Xariep District in the Free State Province and Kanana Township in the Klerkdorp (KOSH) Municipality in the North West Province. Such information is required by both the government and OVC-related agencies such (that is, non-government/faith-based/community-based organisations working with OVC on the ground) for planning their work. Furthermore, this type of information is useful as a baseline to determine the impact of the work done by these organisations. It was for this reason the censuses of OVC in the two areas were conducted during late 2003 and mid-2004.

The main aim of this research was to obtain a count of all the OVC in all eligible households in each of the two sites, as well as information about their caretakers, the number of other children being cared for, the nature of their accommodation and the household economic situation. Thus, the ultimate aim of the study was to determine exactly how many OVC there are in two sites and to obtain an OVC sampling frame for conducting a baseline survey for OVC psycho-social survey in the two areas.

The entire population in all households among the previously disadvantaged communities in the nine small towns in Kopanong Municipality and in Kanana Township served as participants in the two censuses.

The results show that the OVC problem in the two sites studied is equally serious, with about a third of households in both sites having a child who is orphaned. Basic utilities were accessible in both Kopanong Municipality and Kanana Township, although sanitation was a major problem in the latter due to continued use of the bucket toilet system. More importantly, most school-age going children attended school and all children could also access primary health facilities in their areas when they were ill. Food intake by some households was a major problem as up to a third of the households were unable to have three meals per day. Over 60 % of households were judged as vulnerable according to at least one of the criteria set for this project in the three countries. The communities' ability to provide adequate support to OVC in the two sites do not appear to be good, as many of the households are living in abject poverty. Household heads are relatively old and in most cases have no formal education. Disability and serious illness of household members added to the bleak future prospects of many households. Furthermore, only a minority of residents in both sites accessed social grants.

The findings clearly suggest the need for the OVC project in the two sites as there are many OVC living mostly under very difficult social circumstances. The information collected is useful both for OVC-related agencies to facilitate their operations on the ground and will also serve to provide a sampling frame for the baseline and follow-up psycho-social surveys that are planned in the two research-driven intervention sites as part of the Kellogg OVC project in each of the three countries.



## ACRONYMS AND ABBREVIATIONS

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CABA	Children Affected by AIDS
CBO	Community-based organisation
CYFD	Child, Youth and Family Development
FBO	Faith-based organisation
HSRC	Human Sciences Research Council
MOU	Memorandum of Understanding
NGO	Non-governmental organisation
NMCF	Nelson Mandela Children's Fund
OVC	Orphans and vulnerable children
SADC	Southern African Development Community
SAHA	Social Aspects of AIDS and Health Programme
SAMM	Surveys, Analysis, Mapping and Modelling
SPSS	Statistical Package for Social Sciences
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
WKKF	WK Kellogg Foundation





# Introduction

## 1.1 Background

During 2001 the WK Kellogg Foundation (WKKF) funded the Human Sciences Research Council's (HSRC) Social Aspects of AIDS and Health Programme (SAHA) to prepare a policy document reviewing social and economic problems linked directly or indirectly to the HIV/AIDS problem in Southern Africa. The brief for the work required that an analysis of problems related to orphans and vulnerable children (OVC) be prepared, together with recommendations on potential interventions in rural development programming. The report (HSRC, 2002) was completed and submitted to WKKF who accepted it. WKKF then asked the HSRC to produce a draft strategy for the care of OVC in Botswana, South Africa and Zimbabwe, a task that was jointly undertaken by SAHA and the Child, Youth and Family Development (CYFD) programme of the HSRC. This was accepted and led to the signing of a Memorandum of Understanding (MOU) between WKKF and the HSRC which required that the latter prepare an Operational Framework for Research-Driven Interventions for Orphans and Vulnerable Children, including performance targets and indicators. The framework was submitted to WKKF and also approved. The MOU also required that the HSRC develop systems to implement and monitor the HIV/AIDS OVC Operational Framework and provide research to support innovative and sustainable models that target OVC as well as families and households coping with an increased burden of care for affected children.

The Nelson Mandela/HSRC Study of HIV/AIDS (2002) recently found that 13% of children aged 2–14 years had lost a mother, a father or both. The study also found that 3% of children aged 2–14 years had lost their mother. This figure (1.9% to 2.8%) is similar to the one calculated from the StatsSA's October Household Survey of 1995 (Anderson et al., 2002). In addition, this study found that 8.4% of children had lost their father. This figure is not that different from that obtained through calculations based on the October Household Survey conducted by StatsSA, which is between 9.5% and 12.5% (Anderson et al., 2002).

Similar orphan statistics have also been estimated by UNICEF (2003). These figures are alarming as they exceed the estimates of roughly 2% of the entire South African population (UNICEF, 1999) or, according to other estimates, between 2% and 5% of the population of children below 15 years of age (Smart, 2000) that occurred before the onset of AIDS. Therefore, the situation has deteriorated as the reverberations of the AIDS epidemic are felt in young adult deaths in South Africa.

Another important finding reported by the Nelson Mandela/HSRC Study of HIV/AIDS (2002) is that just 3% of households were reported as being headed by a person between the ages of 12 and 18 years of age, and could thus be called a child-headed household (Gow & Desmond, 2002). The percentage observed was 3.1% in urban formal areas, 4.2% in informal urban areas, 2.8% in tribal areas and 1.9% in farms. No other statistics are currently available on the number of child-headed households.

## 1.2 Definitions of orphanhood and vulnerability

In the context of the HIV/AIDS epidemic, UNAIDS defines an orphan as a child who has lost its mother (a maternal orphan) or both parents (a double orphan) before the age of 15 years (Skinner et al., 2004). At this stage, up to two or three times as many orphaned children are not covered by this definition because they have lost a father, rather than a mother (UNICEF, 1999). The reason for the greater number of paternal orphans is that men have higher mortality rates than women of the same age, and women tend to have children with men who are older than themselves. UNAIDS has chosen not to try and count or target paternal orphans because, in many parts of the developing world, fathers are often only loosely connected to children and the households in which they live. However, the figures indicate some of the dilemmas involved in targeting 'orphans' by the UNAIDS definition.

Many more children than maternal orphans are vulnerable because they have lost their main breadwinner, because their mother is sick and unable to care for them, or because their family has taken in the children of kin who are sick or who have died as a result of which the household resources have to be shared among many more people. Large numbers of children in South Africa, between 10% and 20%, live most of their young lives with close relatives, grandmothers and aunts, and would not be classified as orphans by the UNAIDS definition if these surrogate mothers died. For this reason, it is preferable to speak of 'orphans and vulnerable children' (OVC) or simply 'children affected by AIDS' (CABA) (Richter et al., 2004).

The latter definition includes all children who are affected by the widespread death and social disarray that follows in the wake of the HIV/AIDS epidemic. It is certainly not acceptable to speak of 'AIDS orphans', as the term is likely to stigmatise children and increase their already considerable difficulties. Children called AIDS orphans may also be resented for being singled out for special assistance from programmes when so many other children who live in poverty have the same needs as they do. It is very seldom known for sure whether someone has died of AIDS because they usually have not been tested for HIV infection, so it is generally not correct to call a child an AIDS orphan. In any case, it makes no difference to the kind of support children need when they have lost intimate caregivers and breadwinners, or what caused the death of their parents. However, we do tend to know more about the numbers of orphans than the more general categories of 'orphans and vulnerable children' or 'children affected by AIDS'.

One of the major challenges for policy makers and programme developers is to estimate the number of OVC. There are currently no reliable statistics available either nationally in South Africa or at district level. As the definition of orphans in this project uses the cut-off age of 18 years, this means that there are clearly more orphans than those determined by both the UNICEF and Nelson Mandela/HSRC Study of HIV/AIDS (2002) orphan definitions as was discussed above. Furthermore, the definition of OVC adopted in the present project is more general and also includes all children who are needy. Indeed, a very much larger number of children have been, and continue to be made, vulnerable to the impact of the AIDS epidemic, although they are not orphans per se.

According to Smart (2003) and Skinner et al. (2004), vulnerable children include children living with sick and dying parents; children who are primarily dependent on a breadwinner who has died as a result of AIDS; children who are in precarious care as a result of being dependent on extremely old, frail or disabled caregivers; and children in

households that assume additional dependency by taking in orphaned children. Although many programmes profess to target orphaned children, they inevitably and rightly include vulnerable children in their interventions as is currently being done in this project.

There is therefore a dearth of reliable local OVC statistics which underpins the holding of an OVC census in each of the two research-driven intervention sites. The detailed information obtained will provide both the local municipality and OVC-related agencies with useful data for their planning purposes as well as the current project to determine the need for OVC interventions.

### **1.3 Prevalence of orphanhood and vulnerability in South Africa**

Smart (2003), and Barnett and Whiteside (2002) asserted that the AIDS epidemic is leaving one or more generations of children to be raised by their grandparents, to live in households with very high dependency ratios, or in child-headed households. Children who have lost their parents to AIDS face a more difficult future than other orphans. They are at greater risk of malnutrition, illness, early school termination, abuse and sexual exploitation. Many will also have to come to grips with the stigma and discrimination often associated with AIDS, which may deprive them of basic social and education services (Whiteside, 1999/2000).

AIDS has both direct and indirect effects on children. The direct effects result from infection and illness of either or both the child and his or her caregivers. As stated above, there are a substantially larger number of children who will suffer indirectly as a result of the HIV/AIDS epidemic. These children are referred to as vulnerable children, or as children in difficult circumstances.

There are currently no figures in South Africa for children living with infected parents. For example, in Thailand for every child maternally orphaned by AIDS, 12 are living with mothers with HIV/AIDS (UNAIDS, 1997). In addition, many children in Africa live with relatives for varying lengths of time in fosterage arrangements. The illness or death of such a foster parent may have as great an impact on a child as the death of a natural parent.

These indirect cases of HIV/AIDS impact are mostly unreported (Foster & Williamson, 2000). Also, children whose families provide financially for relatives affected by AIDS, or whose mothers take on or go to care for sick relatives may experience a reduced quality of life. In addition, all children are affected when there are increased deaths in their community, and when their close and extended family, community and societal institutions and services are strained by the consequences of the AIDS epidemic.

In general, 'the common impacts include deepening poverty, such as pressure to drop out of school, food insecurity, reduced access to health services, deteriorating housing, worsening material conditions, and loss of access to land and other productive assets. Psycho-social distress is another impact on children and families, and it includes anxiety, loss of parental love and nurture, depression, grief, and separation of siblings among relatives to spread the economic burden of their care' (Williamson, 2000, 3). Children may also become more vulnerable to sexual exploitation.

The impact of the AIDS epidemic on children and families is incremental (Foster & Williamson, 2000). Worst hit are communities that are already poor, with inadequate

infrastructure and limited access to basic services. For example, not taking into account the effect of the AIDS epidemic on socioeconomic conditions, it is estimated that 61% of children in South Africa live in poverty (Smart, 2000). It is these children whose family and household conditions will further deteriorate with the impact of the AIDS epidemic.

There is consensus that help for orphans should be targeted at supporting families and improving their capacity to cope, rather than setting up institutions for the children as orphanages are not a sustainable long-term solution (UNAIDS, 2000). In addition, institutional care itself is known to have deleterious effects on children. Children sent away from their villages may lose their rights to their parents' land and other property, as well as their sense of belonging to a family and a community.

#### **1.4 Rationale and aims of study**

The main aim of this research was to obtain a count of all the OVC in all eligible households in each of the two sites.

The study had the following specific objectives:

- to determine exactly how many OVC there are in the two project sites of Kopanong Municipality and Kanana Township; and
- to obtain information about their caretakers, the number of other children being cared for, the nature of their accommodation and the household economic situation.

#### **1.5 Conceptual framework**

The South African Human Sciences Research Council (HSRC) together with its partners within the SADC region were commissioned by the WKKF to develop and implement a five-year intervention project on OVC as well as families and households coping with an increased burden of care for affected children in Botswana, South Africa and Zimbabwe.

The goals of the project are to:

- improve the social conditions, health, development and quality of life of vulnerable children and orphans;
- support families and households coping with an increased burden of care for affected and vulnerable children;
- strengthen community-based support systems as an indirect means to assist vulnerable children; and
- build capacity in community-based systems for sustaining care and support to vulnerable children and households, over the long term.

The need by intervention agencies to have accurate, reliable, up to date statistics and broad-based information in order to efficiently execute their work cannot be over-emphasised. Population censuses are a principal means of collecting basic population statistics as part of an integrated programme of data collection and compilation aimed at providing a comprehensive source of statistical information for economic and social development planning, for administrative purposes, for assessing conditions in human settlements, for research and for commercial and other uses. The value of each census is increased if the results can be used together with those from other investigations. This OVC census was therefore conducted in order to document the extent of the problem in the selected districts by conducting a house to house enumeration exercise.

It also locates households and communities with children in need of assistance without biases or prejudices.

The use of census data as a base or benchmark for current statistics can furnish information needed for conducting other statistical investigations. This was the secondary aim of the census, that is, to provide a good basis for sampling frame for other scientific studies. The statistics generated usually provide good estimates of prevalence and sample size determination.



## CHAPTER 2



# Methodology

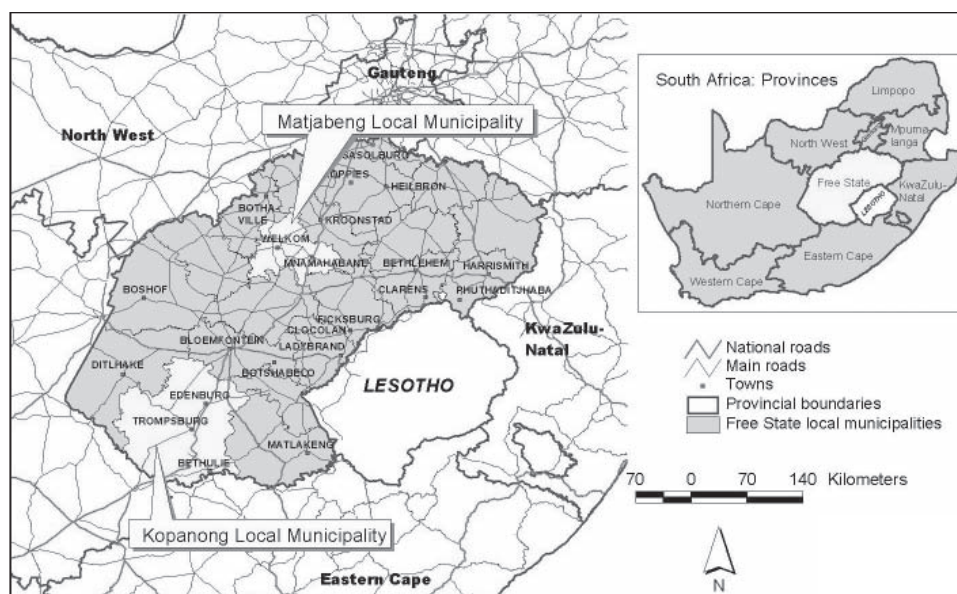
## 2.1 Introduction

In this chapter, a brief description of each study site and sample is presented. Details regarding data collection and management research are also described. Finally, an overview of the ethical procedures of this research is presented.

## 2.2 Description of the site

Kopanong Municipality is a local municipality in the Xhariep District of the Free State Province (see Figure 1). Its population is estimated at 40 906 with 52% females. The number of households is estimated at 13 134 (Skinner & Davids in press). It is predominantly rural with many farms and a number of small farming towns, namely, Trompsburg, Edenburg, Reddersburg, Bethuelle, Jagersfontein, Fauresmith, Phillipolis, Gariiep Dam and Springfontein. About 23% of people of working age are gainfully employed while 11% are unemployed. About 10% of households report no income while 13% live below the poverty line. The statistics on HIV infection in Kopanong Municipality are unknown, as is the case for nearly all districts in the country. The closest HIV prevalence estimate available for the area is for the whole Free State Province. According to the Nelson Mandela/HSRC Study of HIV/AIDS (2002), the Free State had the highest HIV prevalence rate nationally, compared to other provinces with 14.9% of all its inhabitants aged two years and older being infected. It is more than likely that prevalence in this relatively rural municipality is lower than the provincial average. As with HIV prevalence, similarly little is known about the number of OVC in the area. Whilst the former is outside of the scope of the present study, the latter is its main focus.

Figure 1: Location of the Kopanong Local Municipality in the Free State province in South Africa<sup>1</sup>

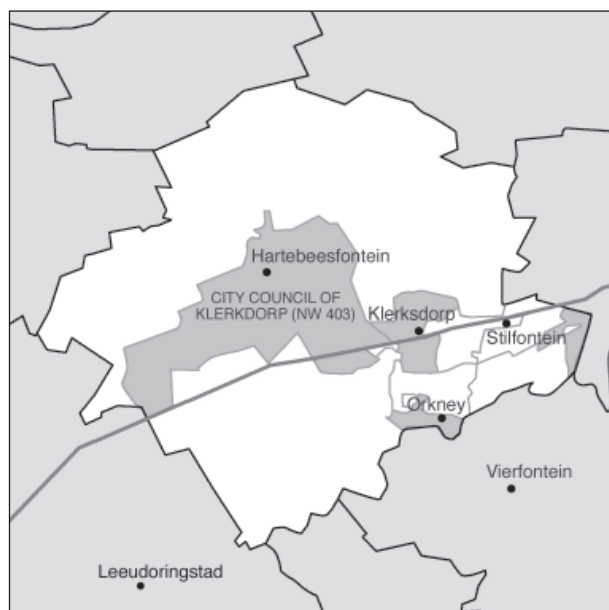


<sup>1</sup> Note: Matjabeng Local Municipality is the second project site in the province in which normal OVC intervention is being implemented as part of the same project.



The second site is Kanana Township, a large township situated in KOSH Municipality in the North West Province. The major industries operating in Klerksdorp include gold mining, trade, medical, transport and government. While some people work in the gold mines found in small towns and economic nodes throughout the KOSH area, a significant proportion of people in Kanana Township are at home during the day on weekdays, which speaks of severe levels of joblessness (Skinner & Davids in press). Consequently, the level of poverty in the township is also high. The media has reported on township residents who, on a daily basis, collect food and other things from a rubbish dump near Kanana. Some of these people include small children. Community members describe the level of crime as very high, with robbery being the most common crime. Poverty and food shortages are key concerns affecting the target communities. Lack of food, lack of means to buy basic clothing, paying of school fees, rent or visits to health facilities were some of the difficulties mentioned. It is estimated that over half (55%) of the people of working age are not gainfully employed (Skinner et al., 2004).

Figure 2 City Council of Klerksdorp<sup>2</sup>



### 2.3 Study sample

The entire population found in all households among the previously disadvantaged communities in the nine small towns in Kopanong Municipality and Kanana township in KOSH Municipality served as participants in the census.

### 2.4 Community preparation

Before the survey was carried out, the research team and partners, namely, the Nelson Mandela Children's Fund (NMCF) spent about two months negotiating community entry with local community structures and community-based organisations (CBOs) working with OVC in the area. This was in order to get the community to buy into the project by accepting its co-ownership with the HSRC and the NMCF. The local government

<sup>2</sup> Kanana Township is situated to the right of Orkney.



(Kopanong Municipality) as well as the Free State's Provincial Departments of Social Development, Education, Home Affairs and Health were also all involved in this process to ensure long-term sustainability of the project after external funding is withdrawn at the end of the project in December 2006.

## **2.5 Research instrument**

The two-page census record sheet (see Appendix A) was used to obtain information about all occupants in the household, including the number and types of orphans, disabled people and various socioeconomic status indicators including measures of the vulnerability status according to the OVC definition used in the project in all three countries.

## **2.6 Data collection**

Once community approval for the project had been successfully obtained, the heads of each household were approached for interviews by an enumerator who was part of a team of fieldworkers led by supervisors who conducted the censuses in the two sites (see Appendix B). The enumerators in the two sites were each trained separately for two days on how to use a two-page census record sheet. Fieldwork was conducted at the start of November 2003 in Kopanong. In Kanana it started in April 2004. Fieldworkers made a maximum of two visits to households, where no one was home or where no one qualified to complete the questionnaire. Fieldwork lasted two to three weeks in both surveys.

## **2.7 Quality control**

Each fieldwork team was lead by a supervisor. Teams met at the end of each day and each questionnaire was checked by the fieldworker who administered the questionnaire. The supervisors edited questionnaires and completed questionnaires were handed to the two or three HSRC researchers who served as project co-ordinators in the field. The co-ordinators remained in the field for the entire duration of the project. They provided technical support to supervisors and the teams of enumerators.

## **2.8 Data management and analysis**

The data capture was outsourced to a private company while data management was done by the Surveys, Analysis, Mapping and Modelling (SAMM) programme of HSRC. The data were captured double-entry by using SPSS and were also analysed using the same package. Most of the analyses were done using frequency distributions and cross-tabulations. The OVC sampling framework was obtained through stratified sampling proportional to size based on both orphanhood and household vulnerability criteria.

## **2.9 Ethical considerations**

Ethical approval for the entire study was obtained from the HSRC's Ethics Committee. In turn, informed consent was sought using an informed consent form (see Appendix C) and obtained from every head of household by the enumerator before the census interview.



## CHAPTER 3



# Results

### 3.1 Introduction

In this chapter the findings are presented of the OVC census held in Kopanong and Kanana. Information is provided separately for both areas. In the first section results are presented on the person level, thereafter household level information is provided.

### 3.2 Kopanong Municipality

#### 3.2.1 Response rate

Table 1 shows the response rate of households during the OVC census held in Kopanong Municipality in November 2003. The majority of households (97%) agreed to participate in the census.

*Table 1: Response rate among households in Kaponong Municipality, OVC Census 2003*

Activity	Frequency (n)	Percent (%)
Completed	5 188	98.6
Incomplete	37	0.7
Refusal	6	0.1
No one present	18	0.3
Abandoned	5	0.0
Total	5 254	100

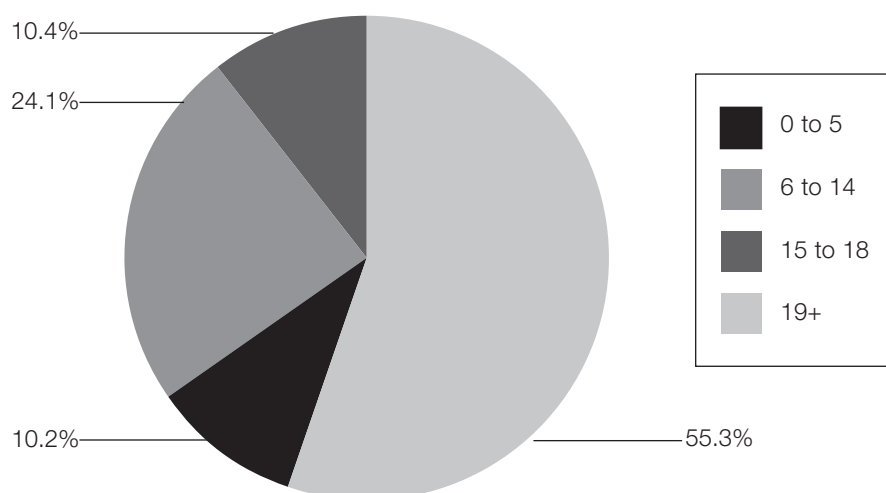
#### 3.2.2 Person-level information

The total population in the 5 225 households that agreed to participate in the census was 21 515. The breakdown of the information gathered about the household members is provided below.

##### 3.2.2.1 Age distribution

The mean age of the population was 27.2 years. The sample was relatively young with almost 70% being younger than 35 years of age. Only 13% of the adults were aged over 50 years. Almost 45% of the population were children aged 18 years and younger (see Figure 3).

Figure 3: Proportion of children and adults in different age groups in Kopanong Municipality, OVC Census 2003



As the main focus of the study is on OVC, most of the results presented below will highlight the findings obtained from children and heads of households. The mean age of children was 10 and over 70% of the children were younger than 15 years of age (see Table 2).

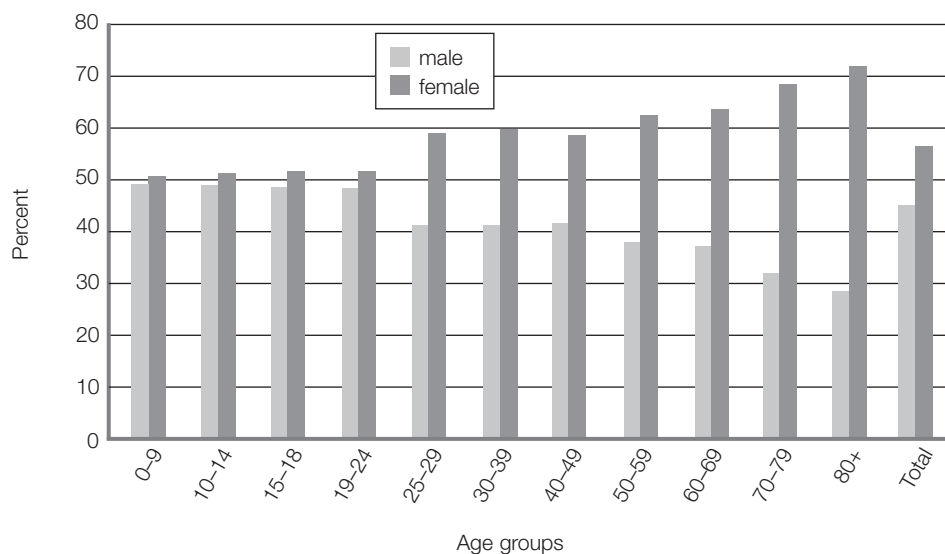
Table 2: Age distribution of children (18 years and younger) in Kopanong Municipality, OVC Census 2003

Age groups	Frequency (n)	Percent (%)
0 to 4	1 747	18.3
5 to 9	2 587	27.0
10 to 14	3 008	31.4
15 to 18	2 227	23.3
Total	9 569	100

### 3.2.2.2 Sex distribution

There were more females (56%) as compared to males (44%). A significant difference was found when comparing the ages of males and females. As depicted in Figure 4, there is a marked decline of adult males in the sample.

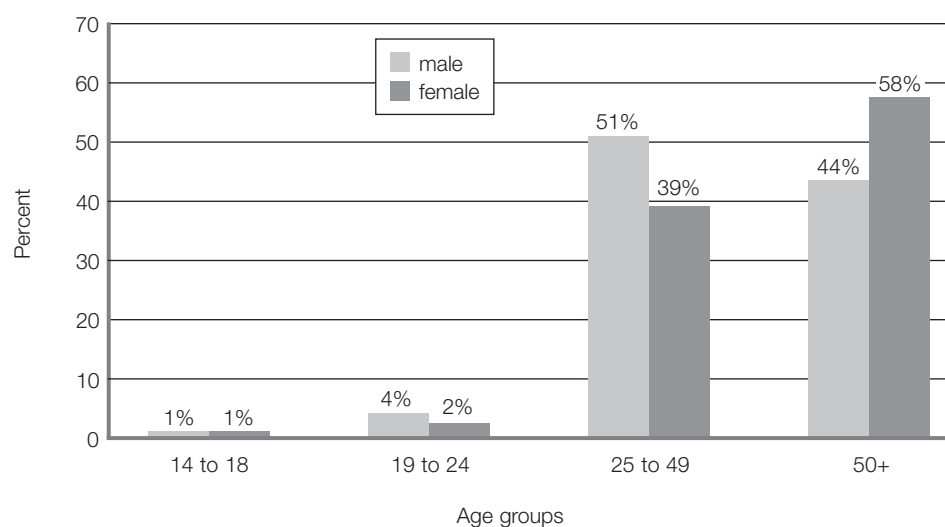
Figure 4: Comparison of people in different age groups (years) and sex in Kopanong Municipality, OVC Census 2003



### 3.2.2.3 Household heads

The majority of the household heads were female (53%). The ages ranged from 14 to 99 years with a mean age of 50.8 years. Only 34 households were child-headed (see Figure 5). Slightly over half (2 598) of household heads were over 50 years of age. One thousand and eighty six of household heads (14%) were 65 years or older.

Figure 5: Age profile of household heads in Kopanong Municipality, OVC Census 2003



### 3.2.2.4 Prevalence of orphanhood

In the present survey information children aged 18 and younger had to provide information about their orphanhood status. We wanted to know whether their mother and father were still alive and whether or not their parents have permanently deserted them. Almost a third (34%) of all children was maternal, paternal, or double orphans. Six percent had lost a mother, and more than three times as many (19%) had lost a father, while 8.3% had lost both parents (see Table 3). The rate of orphanhood did not vary by the sex of the child. It did however increase with age; the rate of orphanhood was highest in the 15 to 18 year age group.

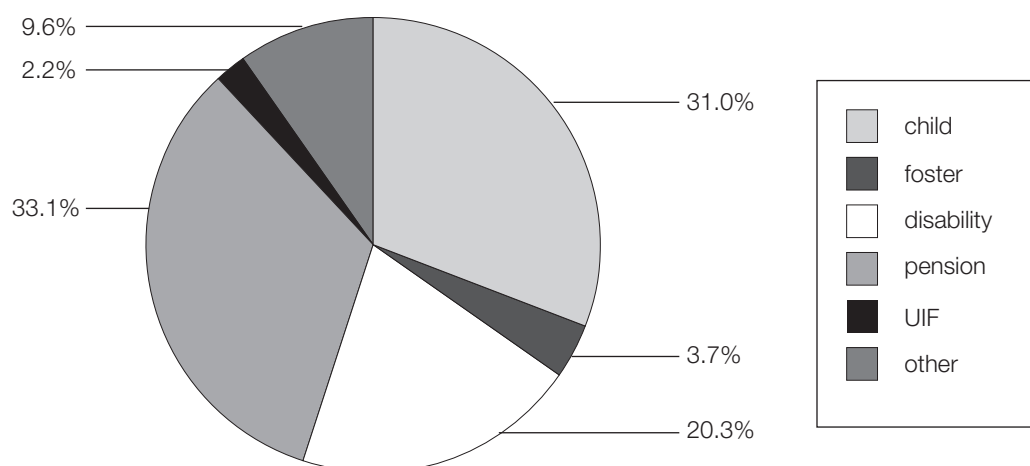
Table 3: Demographic characteristics of orphans in Kopanong Municipality, OVC Census 2003

Gender	Total (n)	Lost both parents (%)	Lost father (%)	Lost mother (%)	Both parents alive (%)
Male	4 067	8.1	18.7	6.7	66.5
Female	4 282	8.4	19.5	6.4	65.7
Age groups of respondents (years)					
0 to 18	8 603	8.2	19.1	6.5	66.2
15 to 18	1 926	11.6	22.5	7.9	58.0
10 to 14	2 732	9.6	19.9	7.6	62.9
6 to 18	6 628	9.6	20.1	7.2	63.1
0 to 9	3 945	5.7	16.9	5.1	72.4

### 3.2.2.5 Government grants

Only 26% of the entire sample reported they received any form of grant. The old age pension and child support grants were the most common grants accessed (see Figure 6).

Figure 6: Nature of grants accessed in Kopanong Municipality, OVC Census 2003



### 3.2.2.6 Education

School attendance was very high with 92% of children aged 6 to 18 years attending school. There was no variation in school attendance by sex or orphanhood status of child. The main reason given for children not attending school was financial difficulties (58%). Almost half (49%) the children aged 6 to 18 years have completed their primary school level of education.

When examining the education level of household heads, the data showed significant differences between males and females concerning school attendance. More females (28.4%) had never attended school as compared to 23.6% of males (see Table 4). A high proportion of both male (38%) and female (40%) household heads aged 50 and older had no schooling.

*Table 4: Education level of household heads by sex and age in Kopanong Municipality, OVC Census 2003*

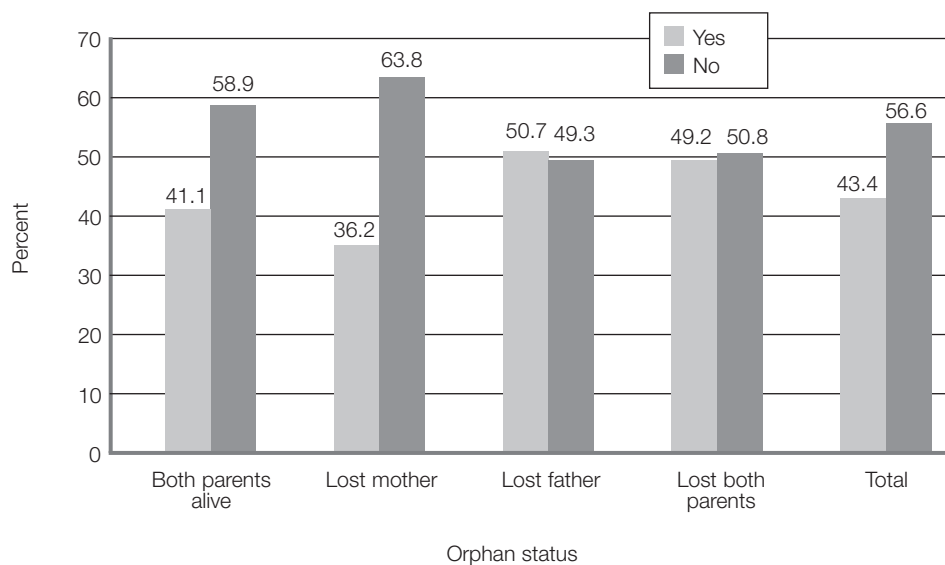
Females	n	Pre-school %	Primary %	Secondary %	High school %	Tertiary %	No schooling %
24 and less	76	9.2	38.2	40.8	9.2	---	2.6
25 to 49 years	753	12.6	44.5	21.2	4.8	2.5	14.3
50 and more	1 078	15.2	35.8	7.7	0.9	0.3	40.1
Total	1 907	13.9	39.3	14.4	2.8	1.2	28.4
<b>Males</b>							
24 and less	96	5.2	42.7	41.7	9.4	---	1.0
25 to 49 years	905	13.4	39.1	26.6	5.3	2.4	13.1
50 and more	684	14.2	34.9	10.5	0.9	1.3	38.2
Total	1 685	13.2	37.6	20.9	3.7	1.8	22.6

### 3.2.2.7 Food intake

Two thirds of all households (68%) had three meals per day. Twenty percent had two meals and only 4% had only one meal per day. No differences were observed when comparing the age, sex of the head of household and orphan status of the sample with number of meals eaten daily.

According to the data gathered 43% of the households had one day of the week where they would not eat any food. A significant difference was observed when examining orphanhood status and food intake. Over a third (3 097) of children who were not orphaned had no meals once a week compared to half (339) double orphans (see Figure 7). Over a third (340) of maternal orphans had no meals once a week compared to half (784) of paternal orphans.

Figure 7: Proportion of children who have no food once a week in Kopanong Municipality, OVC Census 2003



### 3.2.3 Household-level information

#### 3.2.3.1 Household living conditions

Only a fifth (22%) of households had a water source within their homes (see Figure 8). The overwhelming majority of households (87%) had access to water on their premises (see Figure 9).

Figure 8: Main water sources in Kopanong Municipality, OVC Census 2003

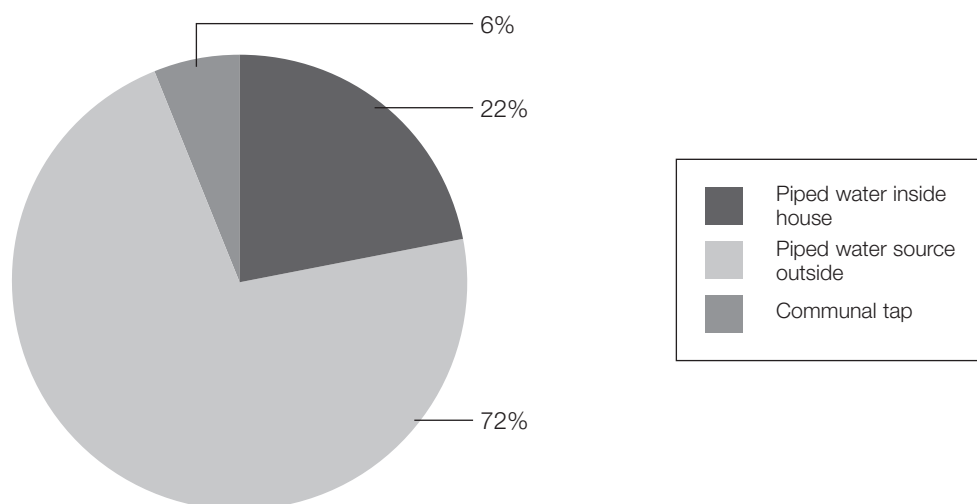
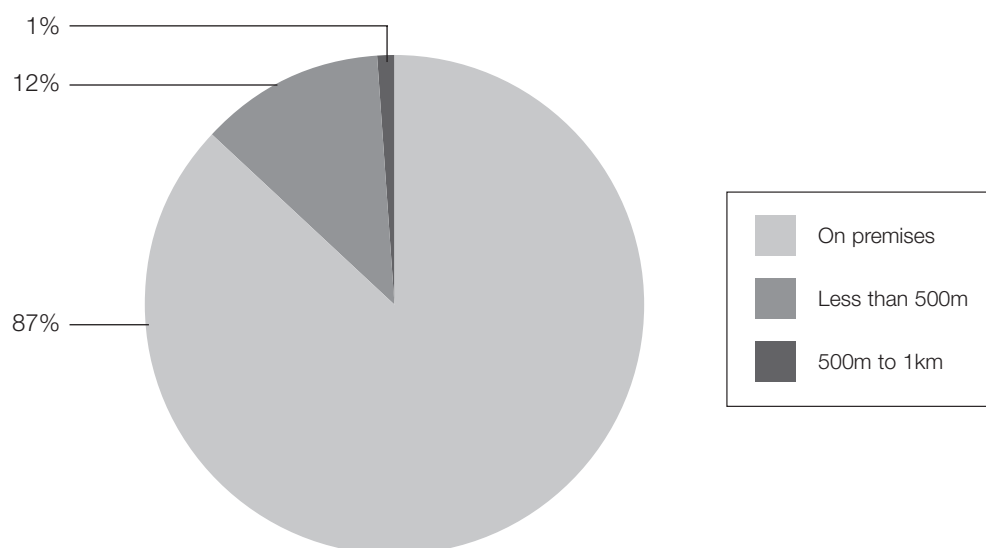




Figure 9: Distance of main water source in Kopanong Municipality, OVC Census 2003



The main source of household energy for light was electricity (83%), whereas for cooking almost 60% of household's preferred to use paraffin. Only a third (35%) used electricity for cooking.

The overwhelming majority of households (86%) had flush toilet systems. Eleven percent indicated that they made use of the bucket system and only 3% had no toilet at all.

### 3.2.3.2 Main indicators of vulnerability

The mean household monthly income is R997.00. More than 60% of households had an average monthly income of less than R851.00 (see Table 5). Almost a third (29%) of the households survived on an average income of less than R651.00, the minimum monthly living wage for a family recommended by the South African Government.

Table 5: Average monthly income of households in Kopanong Municipality, OVC Census 2003

Income categories	Frequency (n)	Percent (%)
Lowest thru 650	1 353	29.1
651 thru 1 200	2 249	48.3
1 201 thru 1 800	630	13.5
1 801 thru 2 400	191	4.1
2 401 thru 3 000	99	2.1
3 001 thru 5 000	84	1.8
5 001 thru highest	48	1.0
Total	4 654	100

The majority of households (69%) were able to access medical services (see Table 6). Almost a third of households (30%) had a seriously ill inhabitant and a fifth (20%) had a household member with a disability.

*Table 6: Main indicators of vulnerability in Kopanong Municipality, OVC Census 2003*

	Yes	No	NA
Are you able to access to medical services?	68.8	16.5	14.7
Do the children have adequate clothing?	51.4	28.6	19.9
Is there anyone who has been seriously ill during the past month?	30.1	69.9	
Do the school going children have adequate uniforms?	51.2	21.6	27.2
Any household member with a disability?	21.5	78.5	

The most common form of disability that occurred among household members were related to difficulty in movement, followed by difficulty seeing, chronic fits/epilepsy and mental illness (see Table 7).

*Table 7: Types of disability in Kopanong Municipality, OVC Census 2003*

Type of disability	Frequency (n)	Percent (%)
Difficulty moving	309	29.8
Difficulty seeing	227	21.9
Difficulty speaking	70	6.8
Difficulty hearing	99	9.6
Chronic fits / epilepsy	137	13.2
Mental illness	121	11.7
Multiple disability	80	7.7
Other	125	12.1

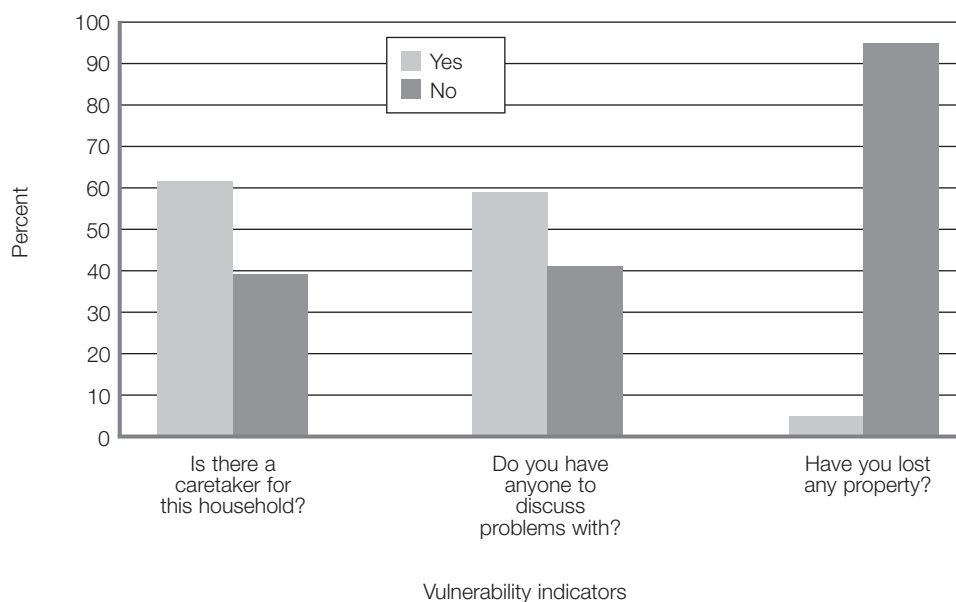
Just over a third (37%) of the households did not score anything on the vulnerability scale. This means that most households (63%) were judged as vulnerable on at least one criterion (see Table 8).

Table 8: Distribution of households on the vulnerability scale in Kopanong Municipality, OVC Census 2003

Vulnerability score	Frequency (n)	Percent (%)
0	1 608	37.0
1	1 154	26.6
2	909	20.9
3	485	11.2
4	154	3.5
5	31	0.7
Total	4 341	100

Sixty percent of the 34 child-headed households reported they had a caretaker for their household (see Figure 10). A similar proportion (59%) had someone to discuss problems with.

Figure 10: Vulnerability of child-headed households in Kopanong Municipality, OVC Census 2003



### 3.3 Kanana Township

#### 3.3.1 Response rate

Table 9 shows the response rate of households during the OVC census held in Kanana Township in April 2004. The majority of households (98%) agreed to participate in the census.

Table 9: Response rate among households in Kanana Township, OVC Census 2004

Activity	Frequency (n)	Percent (%)
Completed	12 762	98.3
Incomplete	17	0.1
Refusal	37	0.3
No one present	74	0.6
Abandoned	94	0.7
Total	12 984	100

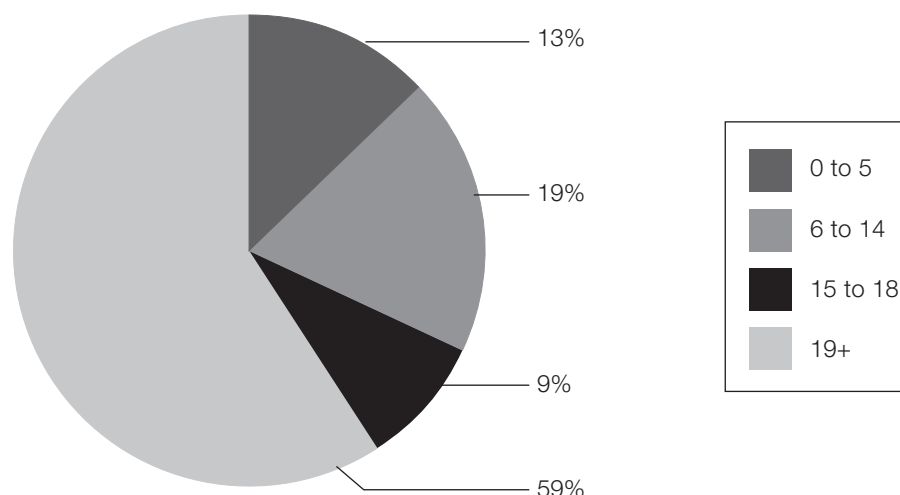
### 3.3.2 Person-level information

The total population in the 12 984 households that agreed to participate in the census was 50 074. The breakdown of the information gathered about the household members is provided below.

#### 3.2.2.1 Age distribution

The mean age of the population was 25.6 years. The sample was relatively young with over 70% being younger than 35 years of age. Only 10% of the adults were aged over 50 years. Forty percent of the population were children aged 18 years and younger (see Figure 11).

Figure 11: Proportion of children in different age groups in Kanana Township, OVC Census 2004



The mean age of children was 9.2 years and over 70% of the children were younger than 15 years of age (see Table 10).

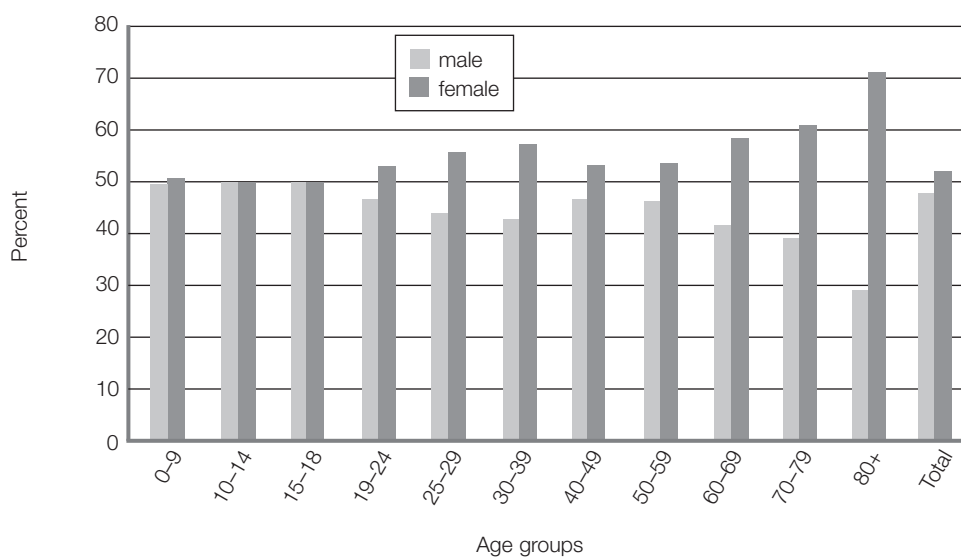
Table 10: Age distribution of children (18 years and younger) in Kanana Township, OVC Census 2004

Age groups	Frequency (n)	Percent (%)
0 to 4	5 325	26.0
5 to 9	5 189	25.4
10 to 14	5 465	26.7
15 to 18	4 485	21.9
Total	20 464	100

### 3.3.2.2 Sex distribution

There were more females (53%) as compared to males (47%). A significant difference was found when comparing the ages of males and females. As depicted in Figure 12 below the proportions of males and females under the age of 50 is similar. There is however a larger male–female sex ratio for the age group 30 to 39. The gap between males and females widens after the age of 60.

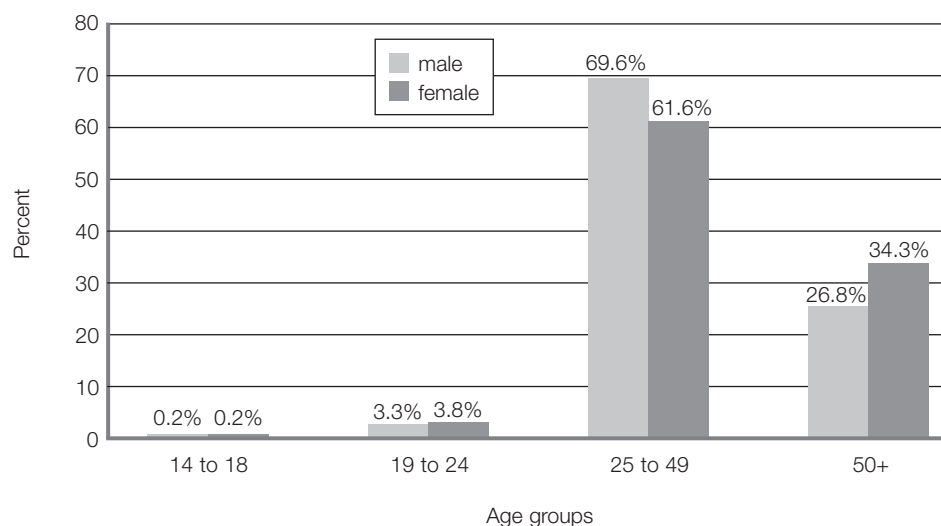
Figure 12: Comparison of people by age group (years) and sex in Kanana Township, OVC Census 2004



### 3.3.2.3 Household heads

The majority of the household heads were male (59.3%). The ages ranged from 12 to 99 years with a mean age of 44.0 years. Only 30 households were child-headed (see Figure 13). Two thirds (65.6%) of household heads were aged 25 to 49 years. Thirty percent of household heads were aged 50 years and older.

Figure 13: Age profile of household heads in Kanana Township, OVC Census 2004



#### 3.3.2.4 Prevalence of Orphanhood

Over a third (39%) of all children were maternal, paternal, or double orphans. Four percent had lost a mother, and more than seven times as many (28%) had lost a father (see Table 11). The rate of orphanhood did not vary by sex of the child. It did however increase with age; the rate of orphanhood was highest in the 15 to 18 year age group.

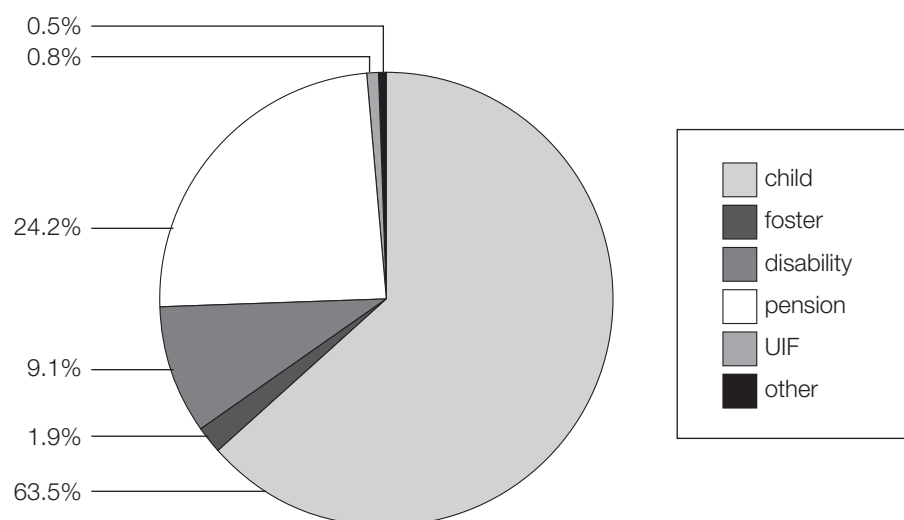
Table 11: Demographic characteristics of orphans in Kanana Township, OVC Census 2004

Gender	Total (n)	Lost both parents %	Lost father %	Lost mother %	Both parents alive %
Male	9 765	6.5	27.9	3.8	61.8
Female	9 865	6.5	28.4	3.6	61.5
Age groups of respondents (in years)					
0 to 18	19 790	6.5	28.1	3.7	61.7
15 to 18	4 294	10.0	30.1	5.7	54.2
10 to 14	5 314	8.7	29.2	4.4	57.7
6 to 18	13 608	8.0	29.3	4.6	58.1
0 to 9	10 182	3.8	26.6	2.5	67.0

#### 3.3.2.5 Government grants

Only 16% of the entire sample reported that they received any form of grant. The old age pension and child support grants were the most common grants accessed (see Figure 14).

Figure 14: Nature of grants accessed in Kanana Township, OVC Census 2004



### 3.3.2.6 Education

School attendance was very high with 92% of children aged 6 to 18 years attending school. There was no variation in school attendance by sex or orphanhood status of child. The main reason given for children not attending school was financial difficulties (50%). Forty-four percent of the children aged 6 to 18 years had completed their primary school level of education.

When examining the education level of household heads, the data showed significant differences among males and females concerning education level. Higher proportions of both male (10%) and female (13%) household heads aged 50 and older had completed tertiary level, as compared to other age groups. The younger generation, aged 24 and younger, had the highest proportions of no schooling.

Table 12: Education level of household heads by sex and age in Kanana Township, OVC Census 2004

Females	n	Pre-school	Primary	Secondary	High school	Tertiary	No schooling
		%	%	%	%	%	%
24 and less	200	5.5	53.0	35.0	2.0	1.5	3.0
25 to 49	2 921	16.8	48.0	27.4	2.4	5.2	0.2
50 and more	1 603	25.3	51.3	9.5	0.9	12.7	0.2
Total	4 724	19.2	49.3	21.7	1.9	7.6	0.3
<b>Males</b>							
24 and less	253	5.9	41.9	43.1	4.0	2.0	3.2
25 to 49	4 834	14.0	46.0	32.4	3.2	4.3	0.2
50 and more	1 835	24.2	49.2	15.1	1.1	9.8	0.7
Total	6 922	16.4	46.7	28.2	2.6	5.7	0.4

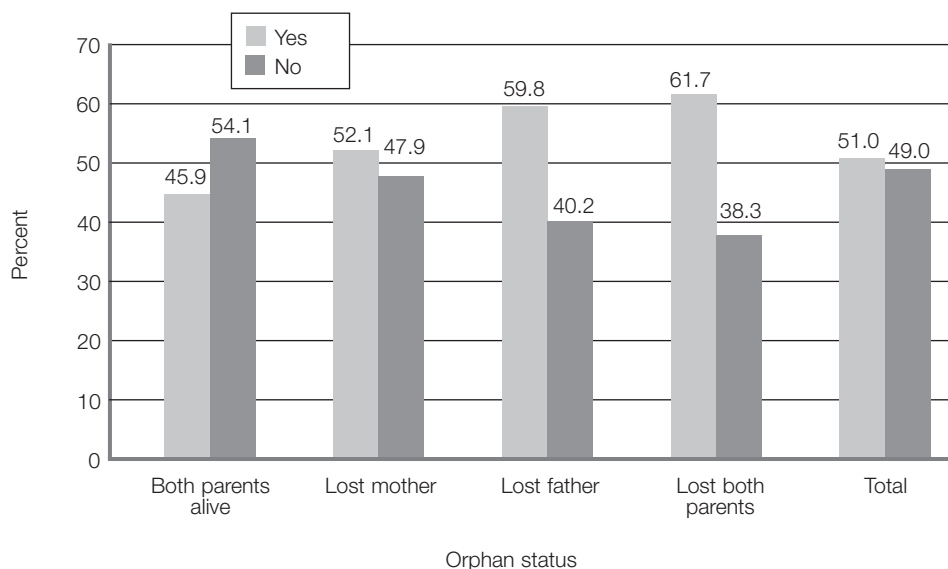
### 3.3.2.7 Food intake

Almost of half the households (47%) had three meals per day. Thirty-eight percent had two meals and only 6% had only one meal per day.

No statistical differences were observed when comparing the sex of the households with number of meals eaten daily. There were however significant statistical differences when analysing the data using age and orphan status.

According to the data gathered, half (51%) of the households had one day of the week where they would not eat any food. A significant difference was observed when examining orphanhood status and food intake. Sixty percent of paternal orphans had no meals once a week compared to 52% of maternal orphans. Sixty-two percent of double orphans had no meals once a week compared to 46% of children who were not orphans.

Figure 15: Proportion of children who have no food once a week in Kanana Township, OVC Census 2004



### 3.3.3 Household-level information

#### 3.3.3.1 Household living conditions

Only 15% of households had access to water within their homes (see Figure 16). The majority (74%) had access to outside piped water, and in most cases the water source was on the premise (see Figure 17).



Figure 16: Main water sources in Kanana Township, OVC Census 2004

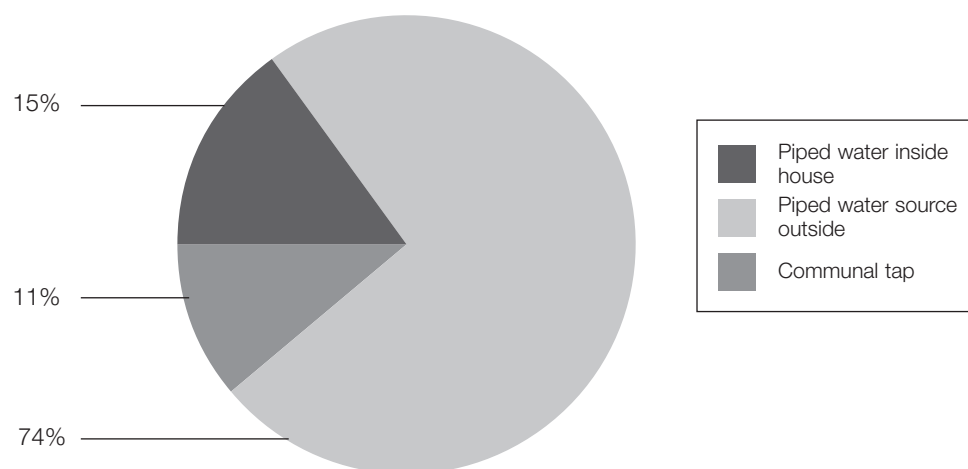
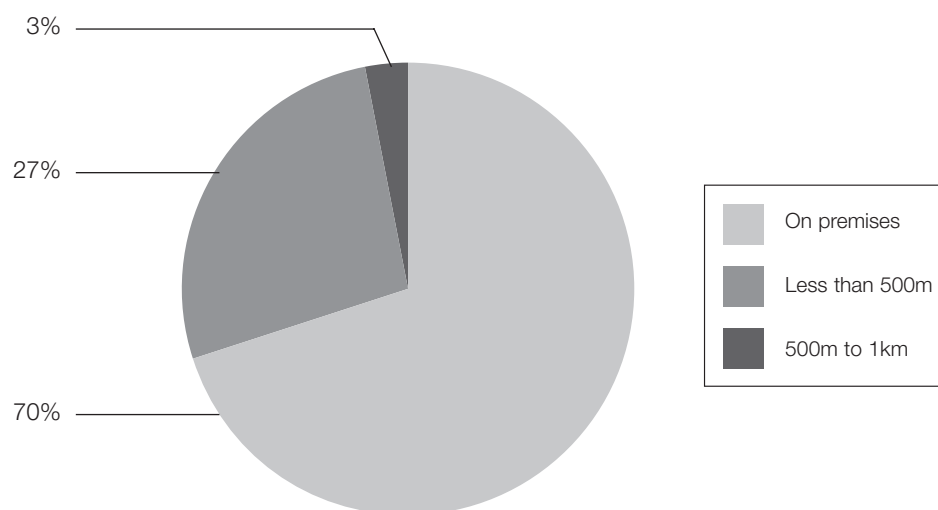


Figure 17: Distance of main water source in Kanana Township, OVC Census 2004



The main source of household energy for light was electricity (86%), whereas for cooking almost 70% of households preferred to use paraffin. Only a 30% used electricity for cooking.

Just over half of households (55%) had flush toilet systems. Forty-three percent indicated that they made use of the bucket system and only 1% had no toilet at all.

### 3.3.3.2 Main indicators of vulnerability

The mean household monthly income is R1 081.00. Sixty percent of households have an average monthly income of less than R851.00 (see Table 13). Over 40% of households survived on an average income of less than R651.00 national minimum family income recommended by the South African Government.

Table 13: Average monthly income of households in Kanana Township, OVC Census 2004

Income categories	Frequency (n)	Percent (%)
Lowest thru 650	4 913	41.4
651 thru 1 200	3 869	32.6
1 201 thru 1 800	1 448	12.2
1 801 thru 2 400	698	5.9
2 401 thru 3 000	458	3.9
3 001 thru 5 000	330	2.8
5 001 thru highest	153	1.3
Total	11 869	100

The majority of households (57%) were able to access medical services (see Table 14). Almost a third of households (31%) had a seriously ill inhabitant and 29% had a household member with a disability.

Table 14: Main indicators of vulnerability in Kanana Township, OVC Census 2004

	Yes	No	NA
Are you able to access to medical services?	57.0	23.3	19.7
Do the children have adequate clothing?	32.3	41.7	26.1
Is there anyone who has been seriously ill during the past month?	31.4	68.6	
Do the school going children have adequate uniforms?	28.6	32.8	38.7
Any household member with a disability?	12.8	87.2	

The most common form of disability that occurred among household members was related to difficulty in movement, followed by chronic fits or epilepsy, difficulty seeing, and multiple disabilities (see Figure 17).

Table 15: Types of disability in Kanana Township, OVC Census 2004

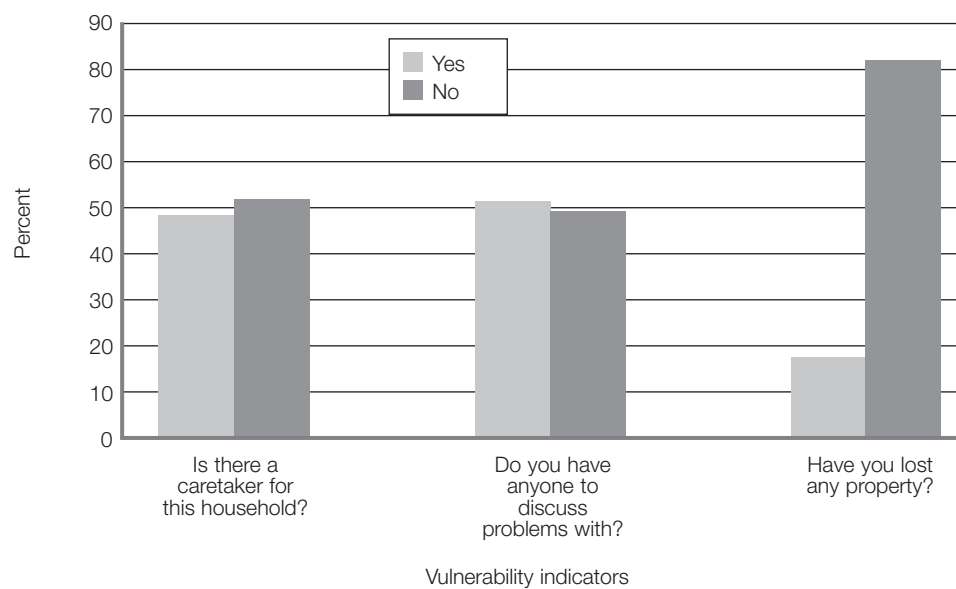
Type of disability	Frequency (n)	Percent (%)
Difficulty moving	320	19.7
Difficulty seeing	234	14.4
Difficulty speaking	86	5.3
Difficulty hearing	149	9.2
Chronic fits / epilepsy	242	14.9
Mental illness	159	9.8
Multiple disability	206	12.7
Other	425	26.1

Just over a third (33%) of the households did not score anything on the vulnerability scale. This means that most households (67%) were judged as vulnerable on at least one criterion (see Table 16).

Table 16: Distribution of households on vulnerability scale in Kanana Township, OVC Census 2004

Vulnerability score	Frequency (n)	Percent (%)
0	3 963	33.4
1	2 703	22.8
2	2 510	21.2
3	1 846	15.6
4	668	5.6
5	169	1.4
Total	11 859	100

Less than 50% of the 30 child-headed households reported they had a caretaker for their household (see Figure 18). Just over half (51%) had someone to discuss problems with.

*Figure 18: Vulnerability of child-headed households in Kanana Township, OVC Census 2004*

## CHAPTER 4



# Discussion

### 4.1 Introduction

In this chapter we focus on the important findings relating to the orphanhood and vulnerability rates among children and the household vulnerability in both sites. The situation of child-headed households is also discussed and the limitations of the study are provided. Recommendations and conclusions drawn from the results of the study are included at the end.

### 4.2 Orphanhood and vulnerability rates

The orphanhood problem in Kopanong Municipality is very serious with over a third (34%) of children aged 18 and younger being orphaned. In Kanana Township, the problem was even worse with a 39% rate of orphanhood found. The problem was especially acute among older children aged 15 years and more. Paternal orphans were the most common in both areas. These findings are consistent with those reported in literature which shows that there are more paternal than maternal orphans in many communities.

There were no differences in the average number of meals eaten per day by orphaned and non-orphaned children. However, significant differences were observed comparing type of orphanhood status and going without food at least once a week as children who were orphaned were more likely to go without food. This finding concurs with reports of lack of food security when one or both of the parents die, and especially when the breadwinner dies.

A particular area of concern, especially in Kanana Township, is that a large number household heads were over 50 years of age, female and had no schooling. This poses several serious challenges. Firstly, being illiterate, they are unemployed and consequently poor. Secondly, also due to illiteracy, they are not aware of their rights to access social grants and hence the very poor levels of access in both sites. Thirdly, they negatively impact on the academic development of the children as they are unable to assist them with their homework.

Another issue deserving some comment is the finding that there were very high levels of school attendance among the OVC in both sites. This finding is not surprising as schooling is virtually free throughout South Africa. Although in some schools fees are payable, the government's policy is that parents and/or guardians are only required to pay if they can afford to. Therefore, the overwhelming majority of the children in general, and OVC in particular, attended school in both sites. It is however of concern that a small minority of the children were reported not to be attending school due to financial reasons.

### 4.3 Household vulnerability index

Two thirds of households in both Kopanong Municipality and Kanana Township were judged as vulnerable according to at least one of the criteria set for the project. The vulnerability situation deteriorates even further, when average monthly household income

is taken into account. A third of households in both sites had earnings less than the minimum monthly amount (R650.00) recommended by the government as the living wage.

Overall, tap water and electricity, as well as health services for children if they fell ill, were widely available to the majority of the households in Kopanong Municipality. Of serious concern is the fact that about half of Kanana Township's households still make use of the bucket toilet system. This places children in these households at a higher risk in developing health problems. It is telling that at the time of the census there had been an outbreak of cholera in Kanana Township due to heavy rains in the area that caused some flooding and overflowing of human faeces in the buckets. Ill health posed an additional burden on a number of households, with a third of households in both sites having at least one household member who was seriously ill during the month before the census took place.

A relatively high number of people had disabilities in both sites. However, especially in Kanana, only a relatively few of the households had access to disability grants. Of great interest also was the relatively high levels of mental illness that were reported, especially in Kopanong Municipality. This issue requires further investigation,

#### 4.4 Child-headed households

The number of child-headed households in both sites was found to be very low. The role of the extended families in both communities could possibly account for this low figure as they are still providing a safety net to OVC, especially orphans. Double orphanhood was found relatively high in both Kopanong Municipality (8%) and Kanana Township (7%). It is possible that unrelated members of their communities might have taken in the overwhelming majority of these orphaned children as part of the spirit of communality (known as *ubuntu*) that exists in many African communities, especially in South Africa. This finding is similar to anecdotal reports by other OVC-related agencies, such as the Nelson Mandela Children's Fund who, when they conducted a situational analysis three years ago in one area in Northern KwaZulu-Natal when they were about to start their USAID-funded 'Goelama' OVC project, could not find many children orphaned by HIV/AIDS and let alone child-headed households (Ms Bongi Mkabela, personal communication 2003). Clearly, it is possible that because of cultural reasons it is difficult to find orphans, as in some African cultures no child is really an orphan and soon after the death of their parent(s) they are 'adopted' by close relatives especially uncles, aunts and grandparents, and then counted as full members of their new households (see Skinner et al., 2004). This provides a social safety net which is being stretched to the limit as the number of children orphaned by HIV/AIDS continue to grow in many Southern African countries, including South Africa (Richter et al., 2004; UNAIDS, 2004).

The support child-headed households received was higher in Kopanong. The property rights of these households appear to have been protected in both communities as only a small proportion were indicated to have lost any property. However, the reliability of this information might be questionable as it was not obtained from the orphans themselves.

#### 4.5 Limitations of the study

There were several limitations, including the following:

- OVC on farms and among white families were not included. Therefore, the prevalence rate is not reflective of the whole population, especially in Kopanong

Municipality. It is known that many desperate previously disadvantaged OVC live on farms and also need help from OVC-related agencies just as those living in towns and cities.

- A few households refused to take part in the census and this might also have caused a slight underestimate of the OVC problem.
- No one was present at home at some of the eligible households and this might also have caused a slight underestimate of the OVC problem.

As with most interview-based surveys, there is some report bias due to social desirability. However, because most of the questions asked were not very sensitive it is hoped that most participants gave valid responses during the data collection.

## 4.6 Recommendations

The following recommendations are made:

- Generally high poverty levels and in particular low monthly household earnings are a major problem in both sites. Interventions that will assist households with income generating activities to improve their ability to care for OVC are urgently needed, especially to improve food security.
- Large numbers of households have members that have disabilities, especially physical ones, as well as mental illness, especially in Kopanong Municipality. These households should be provided with assistance in accessing the relevant government social grants.
- Low literacy levels of household heads are an area of concern. Adult basic education programmes should be promoted. Furthermore, some direct support must be given especially to illiterate grandmothers who can not help the children living with them to do their homework and/or access social grants.
- A high proportion of children attend schools. This provides an ideal venue to make sure that children receive adequate nutrition supplements. The few children that are not attending school must be encouraged to do so.
- The health problems posed by the bucket toilet system in Kanana Township need urgent attention. The KOSH Municipality must immediately look into improving the sanitation system by installing the Blair toilet.

## 4.7 Conclusions

The orphanhood problem and indeed OVC in the two sites studied is very serious. The communities' ability to provide adequate support to OVC is not very good. Many households are living in abject poverty. Household heads are relative old and in most cases have no formal education. Disability and serious illness of household members adds to the bleak future prospects of many households.

School attendance among children of school-going age was very high. This practice should be encouraged and maintained. Access to basic utilities is generally good except for sanitation in Kanana Township. Overall, the two censuses achieved the purpose of establishing a sampling framework for households with OVC. This was used to conduct baseline PSS surveys.

## Questionnaire

Location of Home				Interviewer Visits		1	2														
A1 Physical Address/Village Name				Date																	
A2 Additional contact details (nearest feature e.g. school)				Result*																	
* Star indicates codes to be used available in code list																					
<b>B List of members of household</b> (Those who normally live here) and fill in the following information																					
B1	B2	B3	B4	B5	B6	B7	B8	B9	B10	B11											
Full names Mark the head of household with a cross	Age  Write age	Gender  1. Male 2. Female	Relationship to head*  Enter the code	Type of orphan*  Above 18 years, don't ask orphan status	Nature of grant received by the person  1. child 2. foster 3. disability 4. old age 5. UIF 6. other, specify	Does this household member have a birth certificate (1 <sup>st</sup> column) and an ID book (2 <sup>nd</sup> column)?  1. yes 2. no	Does this person attend school? If no, have they ever been to school? Up to age of 25  1. Yes 2. No, attended before 3. Never been to schools If NO Go to B10	Highest level of education completed.  1. Pre-school 2. Primary 3. Secondary 4. High School 5. Tertiary (Non-degree) 6. Tertiary (Degree)	If (name) is not at school, what is the main reason?  1. Financial constraints 2. School too far away 3. Ill/sick 4. Pregnancy related 5. Completed 6. Other	Indicator of food intake. 2 questions,  1st column How many meals do you have per day?  2nd column Is there one day a week where you normally do not have any food? 1. Yes 2. No											
1.		1	2	0 1 2 3		1	2	1	2	3	4	5	6	1	2	3	4	5	6	1	2
2.		1	2	0 1 2 3		1	2	1	2	3	4	5	6	1	2	3	4	5	6	1	2
3.		1	2	0 1 2 3		1	2	1	2	3	4	5	6	1	2	3	4	5	6	1	2
4.		1	2	0 1 2 3		1	2	1	2	3	4	5	6	1	2	3	4	5	6	1	2
5.		1	2	0 1 2 3		1	2	1	2	3	4	5	6	1	2	3	4	5	6	1	2
6.		1	2	0 1 2 3		1	2	1	2	3	4	5	6	1	2	3	4	5	6	1	2
7.		1	2	0 1 2 3		1	2	1	2	3	4	5	6	1	2	3	4	5	6	1	2
8.		1	2	0 1 2 3		1	2	1	2	3	4	5	6	1	2	3	4	5	6	1	2
9.		1	2	0 1 2 3		1	2	1	2	3	4	5	6	1	2	3	4	5	6	1	2
10.		1	2	0 1 2 3		1	2	1	2	3	4	5	6	1	2	3	4	5	6	1	2
11.		1	2	0 1 2 3		1	2	1	2	3	4	5	6	1	2	3	4	5	6	1	2
12.		1	2	0 1 2 3		1	2	1	2	3	4	5	6	1	2	3	4	5	6	1	2
13.		1	2	0 1 2 3		1	2	1	2	3	4	5	6	1	2	3	4	5	6	1	2
14.		1	2	0 1 2 3		1	2	1	2	3	4	5	6	1	2	3	4	5	6	1	2
15.		1	2	0 1 2 3		1	2	1	2	3	4	5	6	1	2	3	4	5	6	1	2
Enter the chief respondent's line number				If Names In B1 Continue Tick In The Box Below And Use Another Sheet-->																	



C Household's Living Conditions										
Main Dwelling Units Type*		1. Traditional	2. Brick	3. Room at back of house	4. Flat	5. Hostel	6. Shack	7. Other (specify)		
C1. Enter number of structures										
C2. Enter number of rooms										
C3. Water for drinking and cooking		C4. What is the household's main source of energy? *			C5. What main type of toilet facility is used by this household? Tick one.					
Main water source *	Distance from water source *	Cooking*	Lighting*	Flush	Pit	Improved pit	Bucket	Nil		
C6. Average monthly expenditure on?		Food	Clothing	Education	Health	Other	Total			
Enter amount in local currency										
C7. What is the household's average monthly income? (Enter Amount)										
C8. Household Income (Enter Amount)										
	1. Remittances	2. Farming	3. Wages	4. Pension	5. Grants	6. Own business	7. Casual Labour	8. Other		
H/h income per annum										
C9. Other Income Indicators - They must be functioning (as observed, or asked) Tick the appropriate response										
Television	Radio	Electric stove	Phone	Car	Manufacturing equipment*		Farm animals*		Farm Equipment *	
C10. External material assistance		Type*	Source*							



## APPENDIX B

### List of supervisors and fieldworkers

#### I. Kanana Township

##### *Supervisors*

1. Rantso Sello A
2. Moilwa Elvis S
3. Mokgatsi Tshepo R
4. Moshoadiba Moeketsi S
5. Mafosi Ofentse D
6. Mphiti Ntombentle J
7. Sephai Motlalepula S
8. Mokone Martha M
9. Ntlekeni Mpumelelo O
10. Dlamini Sibongile M

##### *Fieldworkers*

1. August Julia D
2. Baba Tiya S
3. Belani Leah K
4. Bhiyo Vuyokazi P
5. Bodaza Madingane A
6. Bojosi Palesa V
7. Chabanku Nomsa G
8. Dhlameni Mahlomola S
9. Diane Semakaleng A
10. Disele Madikgomo A
11. Dithato Caroline-Rose M
12. Dlova Fezeka
13. Dube Lesego A E
14. Gama Nwabisa
15. Gwangqa Mncekeleli
16. Hans Nomthandazo Daisy
17. Kalaote Albert Ntate
18. Kgabo Maletsatsi S
19. Kgwabane Fulata M
20. Kgwasi Leejoane A
21. Kgwasi Nokufa A
22. Khoza Mamopedi V
23. Khumalo Kedibone M
24. Kobeli Mosika J
25. Konopi Rasekene J
26. Lehihi Ephraim D
27. Lekgari Thabiso N
28. Lekone Pule I
29. Leoma Tsokolo J
30. Letebele Limpho C
31. Letsie Ernest
32. Letsie Mapaseka E
33. Letsie Mpeleng J
34. Letsoenyo Mokhethi P
35. Lowane Lazarus L
36. Ludziya Patience L
37. Madaka Zanevonga C
38. Mafabatho Mabareng E
39. Mafuya Nobathwa A
40. Mahala Nomthandazo L
41. Makhalotsa Mantamle J
42. Makume Mohanoe J
43. Maleshane Paul T
44. Maloka Thabang S
45. Maoeng Mantoa A
46. Maoeng Olga
47. Maputle Thabo B
48. Marake Doreen K
49. Marumo Lucia L
50. Masekwane Granny M
51. Mashaba Chipa J
52. Masoka Kedibone D
53. Matlawe Moleko E
54. Matlawe Neo U
55. Mbandezelo Lungiswa C
56. Mdupe Reuben K
57. Medupe Mamokete M
58. Melela Kelebogile P
59. Melk Molelekeng J
60. Mmetseng Malhlohonolo B
61. Mocumi Dikeledi G
62. Modise Magdeline D
63. Modise Palesa J
64. Modise Petronella T
65. Modise Tebogo G
66. Mogakwe Ntebaleng C
67. Mojela Queenmary M
68. Mokgatsi Mojaki W
69. Mokgatsi Rachel M
70. Mokgatsi Seipei P
71. Mokgele Ramakhunwana S
72. Mokgothu Paseka E
73. Mokhachane Dinakatso M
74. Mokoena Modibedi S
75. Mokone Makgisana J
76. Mokone Motete E
77. Mokone Neria M
78. Molefe Nceba N

79. Molefi Ishmael K
80. Moleje Yvonne N
81. Molete Lahliwe W
82. Molisalife Molebogeng E
83. Monnakama Kediheng I
84. Montshioa Katlego C
85. Mosala Lebogang C
86. Moshoeshoe Lindiwe H
87. Mothale Selina
88. Motlodi Mali J
89. Motseare Ntswaki J
90. Motseokae Kelebogile H
91. Motseokae Siphon C
92. Motsumi Mamorweng C
93. Mphori Moeketsi D
94. Msindo Bongimvano
95. Mvala Mzamo M
96. Mvala Ntombizodwa M
97. Nanamba Papa S
98. Ndaba Sarah E
99. Ndindwa Kholiswa R
100. Ndlangisa Mthimkhulu J
101. Ndzima Yolisile
102. Ngeni Mntukazi J
103. Ngobese Tlharese P
104. Nkatshela Themba H
105. Nkatsoana Boitumelo D
106. Nkebe Sbongile N
107. Nobula Ourlia O
108. Nomandla Princess N
109. Ntlekisa Vusumzi D
110. Nzima Deluwe
111. Oompie Jacqueline T
112. Oompie Jessica Thandi
113. Phalatsa Mateko M
114. Phiri Godfrey
115. Pienaar Nomthandazo C
116. Pitso Sara T
117. Qotwane Nonceba R
118. Ramarou Thloriso M
119. Ramcwani Siphon P
120. Rampou Nicholas M
121. Sebegon Sister
122. Sebolao Sello F
123. Seithholo Rebecca K
124. Selala Michael
125. Sello Mmathalaba D
126. Selogiloe Adeline M
127. Seroka Sebatane S
128. Setenane Alice M
129. Setlhabi Evelyn M
130. Shongwe Melvin J
131. Sibeko Rethabile W
132. Sibeko Retselisitsoe I
133. Taaibos Christopher
134. Tau Menti M
135. Tau Setshego T
136. Thabatha Nikelwa M
137. Thabethe Manneo S
138. Theiso Brenda P
139. Thetela Neo C
140. Thomas Kelebogile I
141. Thukoane Moramang M
142. Tsheku Selomo D
143. Tshoniswa Tshidiso Z
144. Voster Kefilwe M

## II. Kopanong Municipality

### *Supervisors*

1. L Rigali
2. Xenzile Gcanga
3. M Mogokare
4. K Mentoar
5. N Khethoa
6. M Motshabi
7. P Mokala
8. MA Jafta
9. M Phaku
10. J Louw
11. Z Green
12. L Halter
13. T Tsuelle
14. T Ralenala
15. D Mokala
16. P Mosunkutu
17. M Matseo
18. J Sakawula
19. S Diamond
20. Miriam Nyongwane
21. J Mandla

*Fieldworkers*

1. M Molathoe
2. MP Pienaar
3. ME Maswabi
4. TG Mthala
5. NE Matayi
6. MM Morwagae
7. KR Moeketse
8. V Sello
9. DM Makhofolo
10. TS Galawe
11. P Tauoa
12. M Mosenene
13. Z Nonduyiswa
14. T Meje
15. VE Mbane
16. S Tselane
17. L Tapu
18. IN Ji
19. Mamello R Nkosini
20. Mthetho Mngomezulu
21. Selwyn De Vries
22. P V Hobe
23. PL Thota
24. S Ngqodi
25. S Wilson
26. KE Nkieane
27. NC Mabilo
28. V Morake
29. W Leken
30. S Matakane
31. MS Leken
32. GM Lekhehle
33. E Matseo
34. NE Fokazi
35. IK Mothupi
36. MS Ntaoleng
37. HJ Matlhape
38. M Mokatsane
39. Jason Meintjies
40. J Plaatjies
41. E Zakhele Dunjane
42. DC Lekhotla
43. LA Mphulenyane
44. E van der Westhuizen
45. Puseletso M Ramotsoane
46. L Rouls
47. SH Ramakoe
48. Nomathemba M Ngqaza
49. SM Mnweba
50. NM Makhasi
51. M Khuse
52. SW Reid

### Informed consent form

The Human Sciences Research Council (HSRC) have been commissioned by the WK Kellogg Foundation (WKKF) to develop and implement a 5-year intervention project on orphans and vulnerable children (OVC) as well as families and households coping with an increased burden of care for affected children in South Africa.

The goals of the project are to:

- Improve the social conditions, health, development, and quality of life of vulnerable children and orphans.
- Support families and households coping with an increased burden of care for affected and vulnerable children.
- Strengthen community-based support systems as an indirect means of assisting vulnerable children.
- Build capacity in community-based systems for sustaining care and support to vulnerable children and households, over the long term.

The main aims of the project are to develop, implement and evaluate some existing and/or new OVC intervention programmes that address the following issues:

- Home-based child-centred health, development, education and support.
- Family and household support.
- Strengthening community-support systems.
- Building HIV/AIDS awareness, advocacy and policy to benefit OVC.

In the Kopanong municipality the Human Sciences Research Council is working along with the Nelson Mandela Children's Fund. The aim is to improve conditions of these vulnerable (i.e., needy) children and their carers in this municipality. Interventions will be done in collaboration with the government departments and local NGOs. As part of the development of these new interventions we first need to determine the number of vulnerable children in this area and the level of need for services. We are here to seek your assistance to achieve this. We will visit every household in this area to collect information about who lives in each house and what the accessibility of crucial services. We kindly request that you provide us with details of

family members who stay in this household- old and young. This list will help us to establish the extent of the need for interventions in this area. The information will also help us do some of the research work that will occur later.

Some of the information that we will require from you will be confidential and sensitive. Other than us noting your physical residential address, you are not required to share your name with us whatsoever. We therefore appeal that you answer this questionnaire as fairly and honestly as possible.

This interview should not take more than 10 minutes of your time. We are asking if you would be prepared to assist us. If you say yes and want to change your mind, you may do so at any point in the interview. We would also like to assure you that all the information that you provide us will be kept confidential; only researchers working on this project will have access to it.

Are you willing to provide us with information about your household?

Yes/No

.....

If yes, continue with the survey.

If no, record the address.

Thank the participant for agreeing to give information.





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