



University of Pretoria  
School of Health Systems and Public Health

# The health and living conditions of children in child-headed households in Siteki, Swaziland

By

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## Dedication

I, [Name], hereby declare that this dissertation, which I hereby submit for the degree of [Degree], was written by me and that all the material contained therein is my own work and that all the material contained therein is my own work and that all the material contained therein is my own work and that all the material contained therein is my own work.

## *Dedication*

**To the memory of my father Samuel Sydney Earnshaw**

Submitted in partial fulfillment of the requirements for the degree of [Degree]

Done at Pretoria, on the 11/11/2006



## Declaration

I, Samantha Earnshaw, declare that this dissertation, which I hereby submit for the degree in Master of Public Health (MPH) at the School of Health Systems and Public Health, Faculty of Health Sciences, University of Pretoria, is my own work and has not previously been submitted for other degrees or diploma purposes at any other institution. All sources used have been quoted and acknowledged by complete references.

Student's signature: \_\_\_\_\_

Supervisor's signature: \_\_\_\_\_

Date: \_\_\_\_\_

Signed at: \_\_\_\_\_

Ethics Committee reference number: **S203/2006**

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### ***Abstract***

In Swaziland it is estimated that approximately 10-15 % of the entire population will be orphans and other vulnerable children by 2010 and that one in ten households in the country today are child-headed because of the impact of HIV and AIDS. As the epidemic continues to devastate families and affect incomes, the traditional safety nets of family and community are stressed and assistance to these children is infrequent at best. The focus of this study is to determine the health and living conditions of children living in these types of households. The population comprised 41 heads of household, caring for 97 siblings among them. Data was collected in a single period between the months of February and April 2007 using the Convenience sampling and employing a semi-structured questionnaire. Children were generally physically healthy, despite not receiving adequate food or balanced diets. Most had access to health facilities or at least sources of medication. Education assistance exists but is limited and abuse was generally not reported due to fear of reprisal. There is a dearth of information on adolescents in Swaziland, the primary caregivers in most child-headed households. Children are not actively consulted and encouraged to participate in helping to solve the problems they are affected by. There is a lack of coordination between caregiver organisations, leading to ineffective and inefficient service provision for this particular vulnerable group. This report gives recommendations for ways in which to begin to overcome these issues, as well as suggestions for further research to better understand, prevent and assist child-headed households.



## **Abbreviations**

|                  |  |
|------------------|--|
| <b>AIDS</b>      | Acquired Immune Deficiency Syndrome  |
| <b>AMICAALL</b>  | Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level |
| <b>AU</b>        | The African Union  |
| <b>CBO</b>       | Community-based Organisation   |
| <b>CHH</b>       | Child-headed Household   |
| <b>CRC</b>       | United Nations Convention on the Rights of the Child                           |
| <b>ECHO</b>      | European Commission's Humanitarian Aid Office                                  |
| <b>FBO</b>       | Faith-based Organisation   |
| <b>FLAS</b>      | Family Life Association of Swaziland   |
| <b>HH</b>        | Head of Household  |
| <b>HIV</b>       | Human Immunodeficiency Virus   |
| <b>KaGogo</b>    | Community Social Centres ("Grandmother's house")                               |
| <b>Lutsango</b>  | Lutsango IwakaNgwane Traditional Women's Regiment                              |
| <b>LL</b>        | Lihlombe Lekukhalela – Community Counsellors                                   |
| <b>MoHSW</b>     | Ministry of Health and Social Welfare  |
| <b>NERCHA</b>    | National Emergency Response Council on HIV/AIDS                                |
| <b>NCP</b>       | Neighbourhood Care Point   |
| <b>NGO</b>       | Non-Governmental Organisation (local and international)                        |
| <b>NPA</b>       | National Plan of Action for Orphans and Vulnerable Children                    |
| <b>OVC</b>       | Orphans and other Vulnerable Children  |
| <b>PHC</b>       | Primary Health Care  |
| <b>PSS</b>       | Psychosocial Support   |
| <b>RHM</b>       | Rural Health Motivator   |
| <b>SOS</b>       | SOS Children's Villages  |
| <b>TIBIYO</b>    | Tibiyo Taka Ngwane (The King's Trust Fund)                                     |
| <b>TINKUNDLA</b> | Swaziland Constituencies   |
| <b>TB</b>        | Tuberculosis   |
| <b>UNICEF</b>    | United Nations Children's Fund   |
| <b>WFP</b>       | World Food Programme   |
| <b>WHO</b>       | World Health Organization  |
| <b>WV</b>        | World Vision   |



# Part 1 – Background

## 1.1 Introduction

This chapter gives the reader a picture of Swaziland and its health system, as well as a definition of what is meant by “child” according to international standards. It also introduces the three main areas that were looked at for this study in determining the living and health conditions of children in child-headed households (CHHs).

## 1.2 Context

Swaziland is a small landlocked country that is bordered by Mozambique and the Republic of South Africa. It is made up of four regions, Hhohho, where the capital city, Mbabane, is located, Shiselweni, Manzini and Lubombo. King Mswati III who is supported by an elected parliament, an appointed Prime Minister, as well as a traditional system made up of appointed chiefs, rules it. Swaziland has a population of just over one million people with about 49% being under 15 years old.

The health system in Swaziland consists of six main hospitals that support approximately 162 clinics and 182 outreach clinics. Despite 77% of the population being rural-based, 90% of inpatient beds are located in the urban areas and Government expenditure on health for the urban population is three times that for the rural population.<sup>1</sup> The health system has come under severe stress due to a lack of adequate staff and because of the triple threat that has hit Swaziland: persistent drought, deepening poverty, and HIV/AIDS. Swaziland is considered one of the countries experiencing a reversal in human development, which covers the dimensions of human welfare: health, education and income, despite being considered a middle-income country.<sup>2</sup>

The impact of HIV and AIDS has affected Swaziland considerably. Similar to many of its neighbours in Sub-Saharan Africa, Swaziland’s slow response has led to the worsening effects of this disease and the current estimate for HIV infected people 15-49 years old is 38.8 percent.<sup>3</sup> This sluggish response has led to a heavier burden of care on the country at the household level. One of the consequences of this is the new phenomenon of CHHs that has arisen in the country and seems to be increasing at a fast pace. In 2002 there were an estimated 10,000 CHHs.<sup>4</sup> Now, the United Nations Children’s Fund (UNICEF) reports that one in ten households in Swaziland is child-headed.<sup>5</sup> It is thought that the total number of orphans and vulnerable children will increase to 120,000 by the year 2010, approximately 10-15 % of the entire population.<sup>6</sup> Recently, however, Swaziland has made a move toward better understanding and



management of this state of affairs by developing a “National Plan of Action for Orphans and Vulnerable Children”. This is a huge and critical step in the country’s attempt to deal with and overcome this problem. It puts forward strategies and interventions and is guided by children’s rights to food, protection, education, basic services and participation.<sup>7</sup>

In spite of these steps to improve the situation of children there is still very little information on the particular plight of orphans who head households in Swaziland. Previous studies conducted specifically on CHH focused on obtaining an estimate of how many exist.<sup>8</sup> The picture painted by this data gives no clear idea of what is really happening in regards to the health and economic status of this vulnerable group. The UN Convention on the Rights of the Child recognises that “the child, for full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding”. It also declared “the child, by reason of his physical and mental immaturity needs special safeguards and care, including appropriate legal protection, before as well as after birth”.<sup>9</sup> These stipulations cover the concerns of children’s food security, health and education.

For the purpose of this research, this paper defines a child as “a human being under the age of 18 years old” as enshrined in the United Nation’s Convention of the Rights of the Child. An orphan is defined as a child whose mother (maternal orphan) or father (paternal orphan), also known as “single orphan”, or both (double orphan) has died.<sup>10</sup> A child-headed household is defined as a home where a child has assumed the normally adult responsibilities in the day-to-day running of a household due to the absence of an adult. This report also recognises CHHs as those in which there is an adult, but she or he, for whatever reason, does not contribute in any meaningful manner to the running of the house, also known as an “accompanied” child-headed household. In this report the term “child-headed family” is used interchangeably with the terms “child-headed household”.

Children become “invisible and excluded” from society when their basic needs are not met and they are exposed to exploitation and other types of harm as a result of their not being appropriately and adequately cared for by a protective adult and / or system (Government and community).

### **Socio-economic factors**

As AIDS kills an increasing number of adults, children are left vulnerable without knowing how to protect their rights. The notion of the child being raised by a village, that also acts as a safety net when parents die is slowly disappearing, as extended families and



community members strain under their own personal burdens. Studies have shown that households that take in orphans are likely to become poorer as a result of taking in more dependants.<sup>11</sup> HIV and AIDS have only amplified the burden experienced at household level because of the twin problems of poverty and drought in most regions of Swaziland. In Swaziland, where maize is the staple food, production falls on average by more than 50% following the death of an adult as a result of AIDS.<sup>2</sup> This reduction of labour, income and food production leads to a household being subjected to ever-deepening poverty. Children are often left in homes, if their property rights are not ignored, with little to no resources. With this loss of social and economic viability, many households are forced to dissolve.<sup>12</sup> In the case of CHHs, kin and community become traditional “safety nets” of sorts. Unfortunately, as the epidemic continues to devastate families and affect incomes, these safety nets are not as durable as originally thought by Government.

### **Education**

The worsening economic problem at the household level has a negative impact on education of children. School is where children not only gain academic knowledge, but is also a place where they can obtain life skills. Any life-saving and enhancing skills that a dying parent did not transfer to the child can be given to the child in formal institutions such as schools. This is a prime environment to show children how to change their own behaviours to prevent them from getting affected or infected by HIV/AIDS. School can also assist in educating children on their legal and human rights and it can teach and provide children with agricultural and technical skills that they can implement immediately in their homes. Regrettably, many studies have shown that for orphans and vulnerable children, remaining in school is a challenge. Even before the death of their parent(s) the child’s education is the first expense to be sacrificed. A study conducted in South Africa found that children with seriously ill parents were more likely to have dropped out of school because of a lack of finance, which was probably diverted to more pressing household needs and care giving activities.<sup>13</sup> A study carried out in Swaziland and South Africa by Save the Children found that there were high dropout rates in communities particularly affected by HIV/AIDS. Many adults seemed not to know how to handle children who had lost their parents because they had not been allotted the right (as guardian or caregiver) to assist the children.<sup>14</sup> This left the children in a precarious position of having to figure out what to do for themselves and their siblings, such as negotiating school fees.

## Health

Children and adolescents have special dietary needs to grow up and become healthy, productive adults. Food security serves as an indicator of what chances a household has for adequate nutrition. A study carried out in Tanzania found that orphans were more likely to go to bed hungry than non-orphans.<sup>5</sup> Without the right diet, their deteriorated health can have immediate and long-term negative impact on their livelihood, such as diminished capacity to perform in school leading to a low socio-economic status. Access to healthcare is also mandatory for children in order for them to be monitored and for prevention methods to be put in place to protect their health. In Swaziland, a poor child is five times as likely to be underweight than a child who is not from a poor family.<sup>3</sup> According to the World Health Organization (WHO), one out of three people in developing countries is affected by vitamin and mineral deficiencies that leave them vulnerable to infections and impaired physical and psycho-intellectual development.<sup>15</sup>

Studies done internationally have shown that the adolescent years are just as critical a time for children. A lack of nutritional care can lead to physical under-development and slow maturation as well as reducing work capacity.<sup>16</sup>

The mental health of children who have been traumatised by conflict, death or abuse is a subject that has been looked at but not in a sufficient manner on the African continent. Within the Swazi context research has been limited and the issue of psychosocial support (PSS) for orphans and other vulnerable children (OVC) has been talked about and recognized, but there is still a long way to cover the need amongst this group. A study done in 2001 in the four regions found that there was a drastic need for PSS amongst orphans.<sup>17</sup>

### **1.3 Rationale**

The lack of research and data available on the topic of CHHs indicates that these types of households are not well understood. The appearance of this type of vulnerable household acts as a signal of the times we live in and how the needs of societies and the families within them are changing. What are found are places where poverty and disease are playing a role in stealing childhood. It is necessary to examine the lives of children who live in such situations in order to better understand the root causes, assess their needs, and thereby improve their future. As war and untreated diseases, especially HIV and AIDS, continue to affect people in a purely negative manner, the number of CHHs is likely to increase, thus strongly testing the future ability of any given society to function



and develop at a progressive rate. This report does not seek to sound any false alarms on the size of this unfortunate side effect of the loss of adult lives; instead, it seeks to continue to keep the spotlight on the impact that the death of parents, due to various causes including AIDS, has on children in Swaziland.

## **1.4 Research Statements**

### **Aim**

The aim is to determine the health and living conditions of children living in child-headed households in Siteki, Swaziland.

### **Objectives of the research**

1. To describe the health and general living conditions of children who head households in the Siteki area of Swaziland.
2. To identify what type of support is needed by this vulnerable group.
3. To provide information to relevant stakeholders who assist orphans and vulnerable children.

### **Research questions**

1. What proportion of child-headed households has access to basic health care services?
2. What are the living conditions of child-headed households?
3. What is the proportion of child-headed households in the Siteki region?

### **Hypothesis**

Children living in child-headed households are suffering from poor health, educational, environmental, socio-economic and psychological disadvantages.

## **1.5 Dissemination**

The findings of this report will be shared with the children who participated through school visits and home visits that the researcher undertook. The findings and recommendations will also be shared with the head teachers of each school, the Ministry

of Health and Social Welfare as well as representatives from UNICEF, the Nelson Mandela Children's Fund in South Africa and Global Orphanage (an orphanage based in Siteki) and World Vision, Swaziland.

## Part 2 – Literature Review



Family in front of their home built for them by World Vision

### **2.1 Introduction**

Most of the countries on the African continent have grappled with how to handle the issue of children in vulnerable situations. More specifically, the issues surrounding CHHs seems to leave Governments in a quandary about what to do about children who are taking on adult responsibilities. This section of the report begins by looking at the Swazi situation in regards to policy development surrounding child issues. It goes on to discuss some initiatives that are in existence or are still being discussed and compares these with other African countries' initiatives that have impacted or will impact the livelihoods and health of children living in child-headed families.

### **2.2 Initiatives Impacting Child-headed Households in Swaziland**

Swazi culture is no different from most other African cultures in that it has always placed an important value on its children and on the use of extended families to take up responsibilities when parents have died. Unfortunately, with the ever increasing disintegration of traditional values such as these and the ever increasing poverty

experienced by families in Swaziland, it has become difficult for either extended families or communities to assist without burdening themselves. In 1991 the National Committee for Children was developed and the following year the first National Plan of Action (NPA) was written up. In 1995 the Government of Swaziland ratified the Convention on the Rights of the Child (CRC). In doing so, the Government committed itself to “respect, protect and promote the rights of children.”<sup>18</sup> In addition the Swazi Government has committed to numerous other international conventions and charters regarding the rights of the child, including The *AU Charter on the Rights and Welfare of the African Child* and the *A World Fit For Children* declaration. In 1999 HIV/AIDS was declared a national disaster and in 2000, the Government started looking into the impact that HIV and AIDS was having on children. In 2001, pilot studies on the welfare of children were conducted in the four regions and the first child-headed household was discovered.<sup>17</sup> The findings of these studies found: a high number of children not attending school as a result of their having to care for sick relatives and inability to cover school fees; abused and exploited children; child migration due to death of parents; early marriages; and hunger. In 2002 a survey commissioned by the Ministry of Health and Social Welfare (MoHSW), was conducted to look at the CHHs situation.<sup>8</sup> This report looked at 10 644 children in all four regions and found that: 4960 children were out of school because of a lack of resources; 83% were not getting any kind of community support; and 61% were living in “poor” or “very poor” housing structures. It also found that 70% of the children living in CHHs were receiving only one meal per day and that same year the Swaziland Government invited the World Food Programme (WFP) back to the country, having been there from 1992 - 1996. A report showed that Swaziland was one of five countries in the southern Africa region in which 15% or more of all orphans became an orphan in 2003 alone while more than one in five will be orphaned by 2010.<sup>19</sup>

Swaziland’s 2003 draft National Policy on Orphans and (other) Vulnerable Children is currently awaiting adoption by cabinet.<sup>20</sup> This draft version highlights particular key issues - education, legal support, child protection, health, psychosocial support, food and nutrition, socio-economic security and care and support. It goes on to give guidelines for implementation and role players to be involved.<sup>18</sup> Regrettably, until it is adopted, none of these goals will be efficiently performed. Two other Bills are currently in draft form that will have an impact on these vulnerable families. These are the proposed Child Law Act which will be a comprehensive law governing everything that has to do with a child’s welfare in Swaziland, and the proposed Sexual Offences and Domestic Violence Act

which is currently sitting in the Attorney General's office awaiting drafting.<sup>20</sup> Another step forward in putting children on the Swazi Government's agenda has been the newly created stand alone committee developed by some members of parliament called the *Children's Portfolio Committee* which is committing itself to all issues impacting on the lives of children. In 2005 the National Plan of Action (NPA) for Orphans and Vulnerable Children 2006 – 2010 was developed.<sup>7</sup> Its guiding principles were as follows:

Every child has the-

- Right to food
- Right to protection
- Right to education
- Right to basic services (including Health)
- Right to participate

#### *Community Care Centre initiatives*

The Neighbourhood Care Point (NCP) initiative was started to accomplish the goals of the NPA by providing places of feeding, psychosocial support and places for children to play. Currently there are 415 NCPs in Swaziland with 220 of them centred in the Lubombo region where Siteki is located. Local women who noticed the increasing numbers of orphans in their community initiated this project. Eventually, UNICEF and the National Emergency Response Council on HIV and AIDS (NERCHA) came to their aid, providing them with maize and water to supply the children with food, as well as some assistance with building facilities that would become the NCPs. The women were responsible for rationing out the food for the children but soon discovered that the food was often not getting to the younger children in the households. They decided to start preparing the food at a central point within the community and these eventually became the NCPs.<sup>21</sup> These centres act as an "entry point" to services in the formal sectors such as birth registrations and informal learning and child health days. There has been a trend, however, in attempting to promote the NCPs as Early Childhood Development centres<sup>22</sup>, which would cause the large majority of vulnerable children who are of school-going age to be excluded from the services, particularly the meals.

The KaGogos were started as a way to provide traditional settings in which to care for community members who were in need. They are located in each of the chiefdoms near the chief's residence and are a centre utilised for impact mitigation, psychosocial support and prevention and care. This NERCHA initiative is supported by the funds of Global Fund through NERCHA.<sup>21</sup> An offshoot to these community social centres is the *Food*





*for Work* initiative that is not widespread. This initiative has occurred only in the Lowveld of Swaziland, an area that has been particularly hard-hit by the drought. Women who participate in projects such as the community feeding schemes at the NCPs are allotted enough food for their own families at home.<sup>22</sup> This also ensures there is no misuse of foodstuffs that are targeted at hungry children in the area. Another initiative is the *Indlunkhulu Fields* initiative, a traditional practice whereby the chief allocates land for the community to grow food for the vulnerable of that community. In Zimbabwe, a similar initiative has helped to build trust between the community and the village heads. Initially, community members in that study were found to be reluctant to participate because they felt that the produce would be misappropriated and not given to the children and families in need. Training in leadership and good governance assisted the local leaders in upholding principles of accountability and transparency leading to the success of the initiative.<sup>23</sup> In Swaziland there is no clear indication of how the gardens are governed (not all chiefdoms have chiefs) and what the community's feelings are (resource shortages, etc). Added to that is the fact that Swaziland has had persistent drought over the last five years and water shortages are still substantial in rural areas; therefore, the viability of the gardens is often tested.

#### *Psychosocial support initiatives*

The *lihlombe lekukhalela* ("shoulder to cry on") initiative was started to protect children from sexual and physical abuse. The idea sprang from the youths who were assisting in the research, and the choice of LL was to be decided in a community forum with children of the community making the final decision.<sup>17</sup> Complementary to this initiative is the *Lutsango* (married women's traditional "regiment"). Women from the community are assigned to certain households to assist orphans with daily living, to help maintain harmony, and to teach the girls to cook amongst other things in the home, although the effectiveness of this is yet to be investigated.<sup>21</sup> The Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level (AMICAALL) and NERCHA work closely in supporting this initiative. Rwanda has the highest number of CHHs as a joint result of the genocide in the 1990s and the HIV/AIDS pandemic. It has had impressive success with the *Nkundabana* model<sup>24</sup> used for CHH care that is similar to the *Lutsango* project in Swaziland. These caregivers are trained in active listening skills (for psychosocial support) and HIV prevention counselling through culturally appropriate support. They also help the children overcome any obstacles such as

problems in school attendance or obtaining food. The Nkundabana (caregivers) are chosen by the children themselves and usually live in the area.

### *Social grants*

When a family living below the poverty level is impacted by a death and thereby loss of income, the result is disastrous for the well being of that family, specifically for the children. A study found that “87% of parents, even if they are aware of their terminal illness, did not attempt to make alternative arrangements for their children before their death.”<sup>11</sup> When children are already traumatised by the reality of a parent or guardian’s death, the fact that they have to figure out how to care for themselves and their siblings can be devastating, worse so than it would be if this was a young adult who is already out of school and earning an income.

In Swaziland there is no law governing the age a citizen is allowed to access a social grant. Anyone who is considered vulnerable, confirmed through the visit of a social worker, and has identification is granted the right to access the funds. Therefore, by default, children who head households are able to access the funds as well. Of course there are problems that emerge with the idea of a 9 year old, for example, being able to get the E240 per month. First, the child must have a birth certificate as proof of identification. Second, no protective measures ensure that the child is not exploited or does not misuse the funds. In other countries, such as South Africa, children who head households have difficulties in accessing child grants despite being eligible when they are 16 years old (the age at which one can get an identity document which is needed to apply).<sup>25</sup> Goldblatt and Liebenberg argue that the South African constitution demands that government ensure the rights of children (18 years and under) who are heading families are protected, allowing them to access social grants. In practice, it has been found that even when youth do apply for social assistance they are not taken seriously, with children sometimes being turned away if they are under 21 years old.<sup>26</sup> Many of Swaziland’s laws, including its constitution, are not clear on the issues surrounding children, but some existing law seems to have worked in a positive manner for CHHs, at least those with identification documents. It is hoped that the new Bills being developed for children in Swaziland will be clear about protections for children who are granted social grants.

Around 2003, Kenya decided to pilot a cash transfer programme after realising that the “safety nets” made up of community and family were breaking down in the face of the HIV/AIDS pandemic.<sup>27</sup> The Ministry of Home Affairs’ Children’s Department started

managing this programme in 17 districts, with the aim of reaching 300,000 of the most vulnerable children in Kenya by 2011. The success rates thus far have been promising, although impact is yet to be measured. It has been suggested that cash transfers (or social grants) can be ideal for dealing with vulnerable households' loss of income, thus loss of food production or purchase power.<sup>28</sup> In the case of CHHs it can be an effective way to relieve child poverty, as long as children are not placed in a potentially harmful position where they are living at higher standards than their neighbours.

### *Education initiatives*

A study in Kenya found that many already orphaned children did not attend school due to a lack of finances and heavy household duties.<sup>11</sup> This problem is compounded even more when the child is a double orphan. In 2002, the Government made some efforts through the Ministry of Education, Tibiyo as well as other national and international partners to ensure the continual education of children who are orphaned by providing half the school fees for single orphans and full fees for double orphans. By 2005 five out of six double orphans and three out of four paternal orphans were receiving bursaries. This process has had its fair share of problems from mismanagement and abuse of funds by Government and school officials to generally poor accounting practices and eligible children not being able to apply through their not having a birth certificate or parent's(s') death certificate(s).<sup>29</sup> A book scheme has been introduced whereby students rent books at  $\frac{1}{4}$  the price instead of having to pay the high cost of books for school, and the Ministry has endeavoured to make the books free at the primary level. All of this is in an effort to keep the levels of enrolment up amongst school-going children.<sup>30</sup>

## **Part 3 – Methods**

### **3.1 Introduction**

The main purpose of this study is to determine and understand the health and living conditions of children in CHHs in order to provide this information to relevant stakeholders so that they can better cater to the needs of these children. For this reason, qualitative and quantitative methodologies have been employed. This chapter covers the methodology, data collection, coding, and data analysis.

### **3.2 Methodology and Process**

In the case of health research that is related to sociological issues, it is important to utilize mixed methods. Both qualitative and quantitative methods are invaluable to

finding out issues and concerns surrounding particular vulnerable groups, such as CHHs. Qualitative methods are important for understanding the meaning of outcomes from the perspectives of the individuals being studied. Qualitative research is invaluable in that it empowers people to discuss their own subjective realities.<sup>31</sup> Study subjects being able to give their own perspective is necessary, especially in the case of aid services because what the aid organisations think is necessary for the aid of individuals is not always what those individuals want or feel they need. On the other hand quantitative methods help the researcher to understand the causation. The most obvious benefit of using quantitative measures is so that “statistical and practice inferences can be made about how one set of findings from, or characteristics of, a particular sample can be extrapolated to the larger population from which that sample is drawn, or to other samples or populations”.<sup>31</sup>

According to Casebeer and Verhoef, included among the reasons to use mixed methods in health research are to identify relevant phenomena, to gain value from both types of data and to develop measures.<sup>32</sup> This study was conducted using both qualitative and quantitative tools within a questionnaire.

Initially, rural health motivators who worked with the local hospital were used to assist in identifying the homes of children who fell within the set criteria. They would indicate what they supposed was an eligible household and investigation would show that it did not quite fit the criteria for this research. After over two weeks of not finding eligible children, the decision was made by the researcher to go to the schools and hospitals to get assistance in identifying eligible children. Schools were chosen according to their location in the areas within and surrounding the urban area of Siteki. Phone calls or cold approaches to the head teachers were then made. The study was explained to them and all teachers approached agreed to allow their students to participate after seeing the approval papers from the University of Pretoria and the Swaziland Government. Concerns were brought up about whether to approach the Ministry of Education, but the researcher was informed that as long as the head teachers were willing then the study would be allowed to proceed.

### ***3.3 Population, Sampling and Inclusion/Exclusion Criteria***

#### ***3.3.1 Study Population***

Siteki is the administrative capital of the Lubombo region, one of the hardest hit by unrelenting drought, poverty and HIV/AIDS. It was a suitable location to conduct a study on CHHs. It was assumed that children in this region, which is largely rural, are more likely to be more disadvantaged in terms of receiving assistance for daily living and that

therefore, they would be in need of more focused support from key role players. It is safe to assume that this crisis can be extrapolated to children living under similar circumstances in other regions. Children targeted for this study are those for whom one or both parents are dead and who have now taken over the adult functions within the household, such as caring for younger siblings and general running of the house, including income generating activities. The researcher did her best to ensure that there was a fair geographical representation of households in the Siteki area.

### ***3.3.2 Sample Size***

The sample size, as determined by a statistical package (nQuery Advisor), was to be at least **thirty-eight** households, with approximately 189 people (assuming five people per household) being studied. Through the method referred to above, the researcher was able to locate 41 households covering approximately 138 individuals in total.

### ***3.3.3 Inclusion / Exclusion Criteria***

- Children who were between the ages of 10 and 18 at the time of the study. This changed once the study began because it was discovered that there were heads of household who were 19 years old and one 20 year old who were still in school. The decision was made to include them, as their lives were similar to those of children who were 18 years old.
- A child who was in charge of running the household on a day-to-day basis, which included responsibility for obtaining food and caring for siblings.
- Any household having an adult who was absent for at least 60% of the time (approximately four days of the week). The researcher found something that had not been considered: that of a household where the adult was too invalid to participate in household functions, leaving the child to be the decision-maker.

Excluded were any households not fitting the above criteria.

### ***3.3.4 Sampling Technique***

Convenience sampling was used to find these heads of household instead of the initially proposed technique of Systematic Random sampling. Unfortunately when approached for house lists, it was found that the town council offices of Siteki did not have a mapping of homes outside the urban area, leaving many homes that fall under the administrative realm out of the picture. To add to this, Swaziland is a homestead culture meaning that homes are built simply according to where the local chief allows one to build (i.e. no planning), and not according to what the council would think of as acceptable. Therefore, the idea of “scientifically” going about choosing eligible

households and selecting individuals (or, in this case, households) from a list whereby every  $k^{\text{th}}$  household is chosen was not viable.

### **3.4 Data Collection**

Eight schools, two primary and six high schools, were chosen. Sitsatsaweni High and Primary (located north-east of Siteki); Tikhuba High school and Mphundle High school (located south-east of central Siteki); Good Shepard High school (near the central part of Siteki); St. Paul's Catholic Primary (to the west of Siteki); and Nazarene High school and Lubombo Central High school (both considered in central Siteki). At the schools, each head teacher was given the required letters of authorisation and gave consent to have the children they had listed as OVCs interviewed. A private room was provided and children were called in as a group and the study explained. Each child was then called back into the room individually and interviewed to check for eligibility. Once a group of eligible children were selected, they returned to the room individually and signed the assent form and were interviewed if they had agreed to participate. At the end of the interview each head of household was then provided with a care package made up of basic foodstuffs as a way of thanking them for participating in the research. In most cases, adult consent was provided by the *in loci parentis* (the regional social worker), a head teacher or a community member (usually the rural health motivator (RHM)) who the child identified as a person who assists them. The research was conducted between February and March 2007.

### **3.5 The Child-Headed Household Questionnaire**

The semi-structured questionnaire was developed by the researcher and contains 74 items with both open and closed-ended questions. It is separated into six sections. These are as follows:

- a. Demographics (items 1 – 10): covers the ages of the child heads; which, if any, of the parents are still living and the number of siblings.
- b. Socio-economics (11-27): investigates the actual living conditions the children stay in (physical description of homes); what kind of support and income they have; who supplies it and how often.
- c. Education (28 –32): covers their school attendance and that of their siblings and how this gets paid for.



- d. Health (33 –58): discusses various health-related subjects such as water and sanitation; occurrence of illness in themselves and their siblings in the last month; access to health services and diet.
- e. Urgent needs (59): an open-ended question that asked the children what they felt their most important and immediate needs were.
- f. Psychosocial support (60 –74): Although definitely health related, it was decided to place the issue of psychosocial support in its own category because it is such an important factor in the health of this vulnerable group. Included in this section are questions on current programmes within communities such as the KaGogo feeding centres and the NCPs.

The questionnaire was presented to the University of Pretoria's ethics committee as well as the Swaziland MoHSW for approval before being utilised for this study.

### **3.6 Analysis**

Frequency tables were used to analyse discrete variables and summary statistics were used for continuous variables. During the analysis phase of the research the questionnaire was divided according to how the questions were asked. All sections were analysed in accordance with current epidemiological analysis methods. Some of the questions were coded and others grouped according to themes. The coding was guided by the research questions. The researcher did this manually.

### **3.7 Ethical Considerations**

The University of Pretoria's Research Ethics Committee (Appendix A) as well as the Swaziland Ministry of Health and Social Welfare (Appendix B) granted ethical approval for this study. The children were asked to sign an assent form (Appendix C) once they had agreed to participate. The children were informed of their rights before commencement of the study and were informed that they could stop the interview at any point without fear of any sort of reprisal from the conductors of this research. To protect confidentiality, participants were not named in any report. The only possibility of harm was in participants feeling uncomfortable when discussing sensitive issues; however, participant discomfort was not observed. Four children alluded to problems that needed immediate attention during this study. Two of the children reported food stoppages without knowing the reasons why these stoppages had occurred. These food stoppages were reported to the relevant NGO working in the area at the time. A 15 year old complained that she needed help raising her four younger siblings, and another reported

feelings of sadness due to past sexual abuse from her older brother. Both of these cases were reported to the MoHSW for further assistance.

## Part 4 – Results and Findings

### 4.1 Introduction

This chapter begins by describing the research development process, stressing some of the significant challenges and how the initial research plan had to be adapted in response to the situation. The chapter then discusses the findings of the study, emphasising the key issues as they arise.

### 4.2 Characteristics of Child-headed Households

Forty-one heads of household were interviewed for this study. A majority of the respondents (71%) were female, which was to be expected, with the highest number being 16 years old. Of the 12 male respondents the ages were spread evenly, with more being 18 years old than any other one age. Between the households there were approximately 97 siblings to the 41 heads of household (HHs).

For the whole group, approximately 35% of the children were 10 years old and under. The number of siblings that were living in each household was separated into the categories of those living with three or fewer siblings (approximately 63.42%) and those with four or more siblings (36.58%).

**Table 1: Sex and Age Ratios of HHs**

| <i>Age</i>   | <i>Male</i> | <i>Female</i> | <i>Total</i> |
|--------------|-------------|---------------|--------------|
| 14           | 0           | 2             | 2            |
| 15           | 2           | 5             | 7            |
| 16           | 2           | 8             | 10           |
| 17           | 2           | 5             | 7            |
| 18           | 3           | 6             | 9            |
| 19           | 2           | 3             | 5            |
| 20           | 1           | 0             | 1            |
| <b>Total</b> | <b>12</b>   | <b>29</b>     | <b>41</b>    |

#### 4.2.1 Parents

In this study it was expected and found that the majority of children were double orphans. Of the maternal and paternal (single) orphans, there were 17 parents still living (10 mothers and 7 fathers). When asked if they knew the living parents whereabouts, the location of seven parents was known to the children. Interestingly, two children had both parents still alive (4.88%). Neither of these children knew the location of the parents in these cases. There were some cases where parents had left the home and had simply never returned. In total, five mothers and two fathers were reported to be living with new families. This indicates that it is not necessarily true that child-headed families are a



result of parents dying. The children were asked if they knew if their parents were well and only two of the 16 who knew reported a parent as being ill.

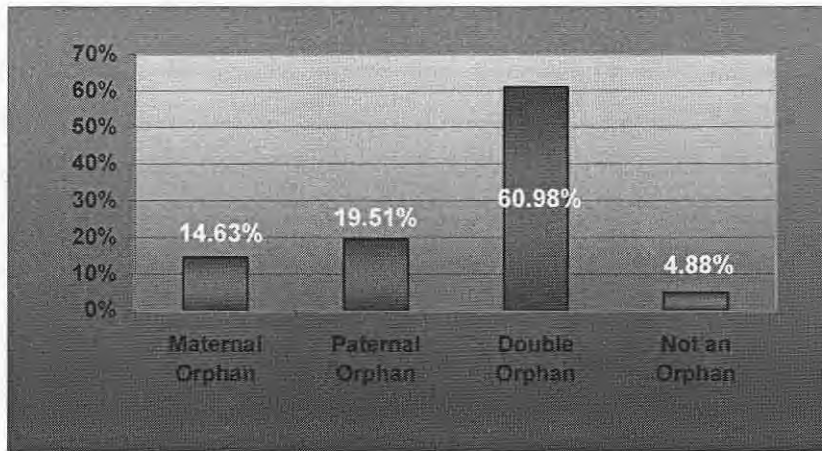


Figure 1: Classification of Orphan Status

When asked about the causes of death for deceased parents, most children could not clearly identify the reasons for death. The children's responses were categorised into "known" and "unknown" causes of death. Examples of known causes were "TB", "burned by her husband" or "car accident" and unknown causes were responses such as "very sick", "headache" and "witchcraft," the last being the response of three of the children. Findings indicated most of the children did not know how their parent(s) had died, unknown causes amounted to mother: 61.76% and father: 58.33%. One of the questions asked the HH if there was an elderly person living in the home; six children indicated that there was an elderly person living there but that person was too ill to do the daily running of the home. All of these elderly people were grandparents, except two, of whom one was a great-grandparent and the other a great-uncle.

#### 4.2.2 Living conditions

The children in this study were found to be generally stable as far as their living environment. More than half (57%) of them were still

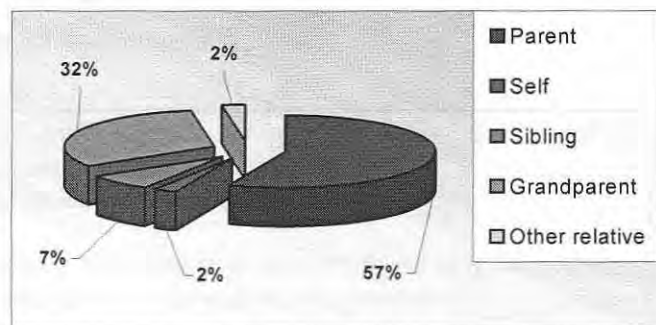


Figure 2: Home Ownership

living in the house owned by the parents,

while another 32% lived in their grandparents' home. When asked how long they had been living in this residence, the majority (65.85%) indicated that they had lived there at least six years. When we look at the fact that most of these children had been orphaned for at least two years, it becomes clear that they had moved into their current home at

least four years before the death or absence of the parent. Two exceptions were young girls and their siblings who had been taken in by neighbours because the state of their home was in an unliveable condition.

Descriptions of the homes were categorised according to materials used for the roof, floor and walls, as well as the total number of rooms in the house. The table below shows the majority of indicated materials that the children described their homes being built from. As shown, most homes had corrugated iron roofing and cement floors. The description of the wall type was spread evenly across the options. As expected most children lived in homes that had fewer than three living areas. A positive aspect of the housing descriptions is that none of the children appeared to be living in informal housing as is more common in urban areas.

**Table 2: Physical Make-up of Homes**

| Structure Type      | Material               | # Of Homes | Percent       |
|---------------------|------------------------|------------|---------------|
| <i>Floor</i>        | <b>Cement</b>          | <b>33</b>  | <b>80.49%</b> |
| <i>Wall</i>         | <b>Mud</b>             | <b>12</b>  | <b>29.27%</b> |
|                     | <b>Cement</b>          | <b>11</b>  | <b>26.83%</b> |
|                     | <b>Brick</b>           | <b>10</b>  | <b>24.89%</b> |
| <i>Roof</i>         | <b>Corrugated Iron</b> | <b>26</b>  | <b>63.41%</b> |
| <i>1 to 3 Rooms</i> | -                      | <b>28</b>  | <b>68.29%</b> |

Despite the fact that the majority of children lived in structures that seemed to be made from modern, sturdier materials, many reported that their homes were in a state of disrepair. Examples of some of the complaints were as follows:

*“Rain comes in a bit (through the roof) and we have to sit in water and the floor is full of holes and coming out”*

**Female, 15 years old, caring for one older sibling**

*“The house is falling down, some people came last year and promised us a house but they still haven’t come and now we sleep at the neighbours.”*

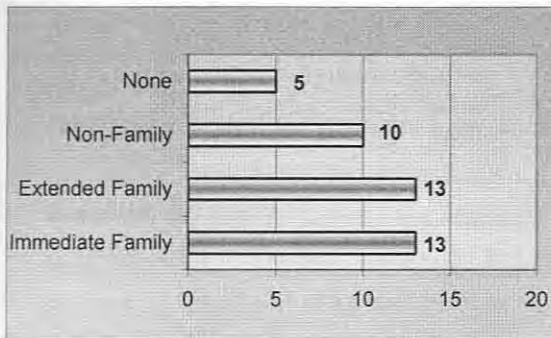
**Female, 16 years old, caring for three younger siblings**

## **4.3 Income and Education**

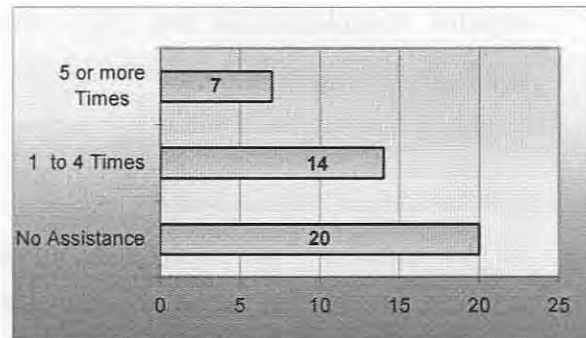
### **4.3.1 Support**

In order to assess the types of assistance the children received, if any, and its source, some questions focused on support and income. A series of questions inquired about

“general assistance”, which was defined as any assistance with food, clothes and any other needs. This series of questions was open-ended and the children were left to decide how to answer them. The figures below speak to assistance from individuals rather than organisations.



**Figure 3: Frequency of General Assistance**



**Figure 4: Frequency of General Assistance in the Last Month**

As Figure 3 above indicates, when the children do get assistance it comes mostly from family members. “Immediate family” included parents (who are still living but are away) and working siblings (who also lived elsewhere) and “extended family” were all other blood relatives. The types of assistance children reported receiving were food, clothing (usually hand-downs from relatives), bus fare (for school), school fees and uniforms or a combination of these. The fact that the children are receiving assistance sounds heartening until one looks at Figure 4, which paints the reality. When asked how often they had received any kind of assistance in the last month, a large number of the children (20) indicated that they had not received any assistance and most of those stated they were not expecting any to come in the near future.

#### **4.3.2 Income-generating Activities**

Of the 41 children interviewed, 15 (36.59%) had been employed in the previous year. Of these 15, none were regularly employed, meaning that they usually worked through school holidays or whenever someone requested their assistance. Those earning under E50 per month at the time of work were the most common (73.33%), with two earning between E100 and E200. Two more earned over E300 per month at the time of working. Those who earned at the lower end of the pay scale were domestic workers (66.67%), who washed and cleaned for neighbours or collected water. The five who did non-domestic work, such as work as a bus conductor or working in a bakery, earned the higher incomes.

### 4.3.3 NGO and Government Support

Of the 36 children who received assistance from community members and relatives, 16 received some additional assistance from NGOs. When asked which NGOs they had received assistance from four were listed: Caritas, a Faith-based organisation (FBO), World Food Programme (WFP), World Vision (WV) and SOS Children’s Villages (SOS). The type of assistance given by these organisations ranged from clothing, food, shelter and school fee payment assistance.

### 4.3.4 Education

All the HHs attended school, as did most of their siblings. Of the 97 siblings, only 26 did not go to school. The reasons varied, as Table 3 below shows. Those listed under the “other” category were generally siblings who had decided to quit school, either to look for work or because they didn’t feel the need to go. These siblings were usually older ones, ranging between 17 and 20 years in age.

The government of Swaziland assists through the payment of school fees and thirty-two (78%) of the children had full or partial payments of school fees through Tibiyo and the Ministry of Education. In the cases where only half was being paid by government, the other half was paid by an NGO or by a relative. Among the rest of the HHs, parents were paying for three of the children’s fees, one by another relative and two more had unpaid school fees. Amongst the HHs, 31 out of the 41 were within walking distance of their schools. The other 10 had to take buses to get there.

Overall, parents and family supported 46% (19) of the children with school uniforms and 22% (9) of the children with schoolbooks. Government was the next highest provider assisting 27% (11) of the children with school uniforms and the schools assisted 46% (19) with schoolbooks through the rental system. Only one child reported not having a uniform and five had no access to school textbooks.

**Table 3: Reasons Siblings Do Not Attend**

| Reasons      | Number of siblings | Percent        |
|--------------|--------------------|----------------|
| Too young    | 6                  | 23.08%         |
| Disabled     | 2                  | 7.69%          |
| Failed       | 3                  | 11.54%         |
| No money     | 2                  | 7.69%          |
| Other        | 13                 | 50.00%         |
| <b>Total</b> | <b>26</b>          | <b>100.00%</b> |

## 4.4 Health and Nutrition

### 4.4.1 Nutrition

The HHs were asked what they had had for their meals (breakfast, lunch and dinner) on the previous day. Table 4 below indicates the meals (if consumed) that the children had eaten the day before. Almost half (19 or 46.34%) of the children indicated they had eaten nothing for breakfast, while three and six of them stated that they had not eaten lunch or dinner respectively. Two children stated that they had not eaten the entire day. Breakfast for most consists of the traditional “soft porridge” made from maize meal. Schools provide meals through the assistance of WFP and this helps with alleviating the problem of hunger for most of the school-going children. These lunches consist mainly of beans and vitamin-enriched maize meal or some other starch foodstuff, while other schools provide bread and juice combinations. For dinner it was encouraging to see many (10) reported having a vegetable (other than beans) for dinner, but the majority still reported the same maize meal and beans combination for dinner.

When asked if the meals and eating habits reported about the previous day were usual, more than half (56.10%) reported that they were. The rest added different variations of the same foodstuffs, such as vegetables for lunch instead of dinner, or bread for breakfast instead of nothing, etc. The participants were also asked if they felt satisfied with each meal they ate (when they ate). Twenty-four (58.54%) of them agreed that they were satisfied while seven reported never being satisfied and 10 reported being satisfied some of the time. Some HHs also reported that they sometimes did not eat a meal so that younger siblings would be able to eat more. One girl stated:

*“Even when there is food at home I don’t eat much because I don’t want my stomach to get used to [a lot of] food.”*  
16 year old, caring for two siblings

As expected, the major source of fuel to prepare food was wood used by 37 respondents (90.24%), while one reported using an electric stove, two reported using gas and one child reported using whatever was available at the time from wood, gas and coal.

**Table 4: Description of Meals Eaten the Previous Day**

| <i>Breakfast Yesterday</i> | <i>Number of children</i> | <i>Lunch Yesterday</i> | <i>Number of children</i> | <i>Dinner Yesterday</i> | <i>Number of children</i> |
|----------------------------|---------------------------|------------------------|---------------------------|-------------------------|---------------------------|
| Bread & Tea                | 3                         | Bread & Juice          | 7                         | Bread & sugar           | 1                         |
| Fat Cakes                  | 1                         | Sweet Potato           | 1                         | Maize meal & sugar      | 1                         |
| Soft porridge              | 9                         |                        |                           |                         |                           |
| Maize meal                 | 1                         |                        |                           | Maize meal              | 1                         |
|                            |                           | Maize meal & meat      | 1                         | Maize meal & meat       | 6                         |
|                            |                           | Rice & meat            | 2                         |                         |                           |
| Maize meal & beans         | 1                         | Maize meal & beans     | 9                         | Maize meal & beans      | 13                        |
|                            |                           | Rice & beans           | 4                         |                         |                           |
|                            |                           | Samp & beans           | 9                         |                         |                           |
| Maize meal & emasi         | 1                         |                        |                           | Maize meal & sour milk  | 1                         |
| Maize meal & veggie        | 4                         | Maize meal & Veggie    | 1                         | Maize meal & veggie     | 10                        |
| Maize meal & soup          | 1                         | Bread & Soup           | 2                         | Maize meal & soup       | 2                         |
| Rice & soup                | 1                         | Rice & soup            | 2                         |                         |                           |
| Nothing                    | 19                        | Nothing                | 3                         | Nothing                 | 6                         |
| <b>TOTAL</b>               | <b>41</b>                 |                        | <b>41</b>                 |                         | <b>41</b>                 |

#### 4.4.2 Water and Sanitation

Results on the access and types of water sources were generally not surprising, as many of the children's homes were located in rural areas. Fourteen of the children collected their water from a river, followed by seven who collected it from a spring. Similar numbers of children reported usage of other sources such as boreholes, taps, dams and pipes. When potentially unsafe sources were compared to safe sources it was found that 68.29% used unsafe sources of water. Only two children voiced concerns about access to water, one stating that sometimes there was no water in the pipe when the cows came to drink and the other stating that she is charged E30 per month by her neighbours to access their tap. In the area of sanitation, it was found that twenty-seven (65.85%) of the children reported access to a toilet; 26 used a pit latrine and one used a

flush toilet. The rest of the children used the bushes near their homes. As far as waste disposal was concerned, most children (63.41%) reported having a rubbish pit near their homes while the rest threw waste into nearby bushes.

#### 4.4.3 Access to Health Services

A series of questions was asked regarding the children’s access to health and welfare services, the types of illness experienced by themselves and their siblings in the last month, and where they obtain their medication from when they are ill. Sixteen (39%) of the HHs reported being ill in the previous month; proportionately, even fewer of the 97 siblings were reported as being ill (13%). The types of illness experienced by both groups were generally minor ailments such as coughs, headaches and rashes. The sibling group reported more major illness (TB, asthma and HIV) than the HHs (malaria). When asked if they had been to hospital in the previous month for themselves or one of their siblings only five reported having done so. The HHs were also asked how they got to hospital if they needed to. The majority reported walking to the hospitals or health centres, which may indicate that most health facilities are within a reasonable distance. The next highest group (14) reported using a bus while three reported the combination of walking and taking a bus.

Within the sphere of access to health care this study attempted to find out where the main sources of medication were for these families. Most children (23) reported using a hospital or other health facility as a source. The usage of RHMs was reported by six of the children while four reported using traditional doctors or herbalists. Those listed in the “other” category used neighbours, friends or shops.

In Swaziland orphans and other vulnerable children such as those in CHHs are the responsibility of the social welfare department under the MoHSW. Children were asked if they had ever been visited by anyone from the department of health for any reason within the last six months. Seven children reported having been visited by someone from the health department. It was found that most of these visits were related to home-based care for the parents and

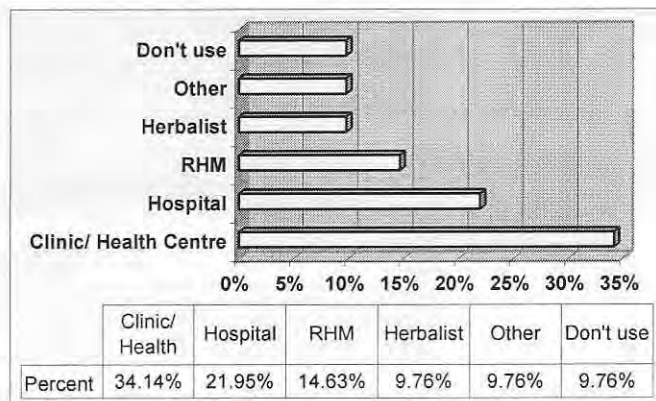


Figure 5: Sources of Healthcare and Medication

follow-up visits for the children. One case was related to the care of the elderly person in the home. What was more disturbing was the fact that only one of the children had been visited by a social worker in the previous six months and she was one of only three who even knew where the social welfare offices were located.

#### 4.4.4 Psychosocial (mental health)

The issue of psychosocial support for children in the position of HHs is one that has not been sufficiently looked at. This study attempted to explore how these children cope psychologically with the fact of having suffered the trauma of lost parents and then being thrust into the role of caregiver to siblings who look to them for support and care. The areas looked at were how they felt emotionally in general, whether they belonged to any social groups, and how often they participated in those. Also asked was whether an adult had ever abused them, and whether they felt comfortable in the communities they lived in.

Children were requested to select from a list of options (happy, sad, angry, stressed and other) to describe how they felt on a day-to-day basis. As expected, most children reported feeling generally sad. An unexpected finding was the response of “okay” in the open option. Nine of the children reported this “feeling”. The children related the fact that they felt they had no real choice but to accept everything, whether good or bad.

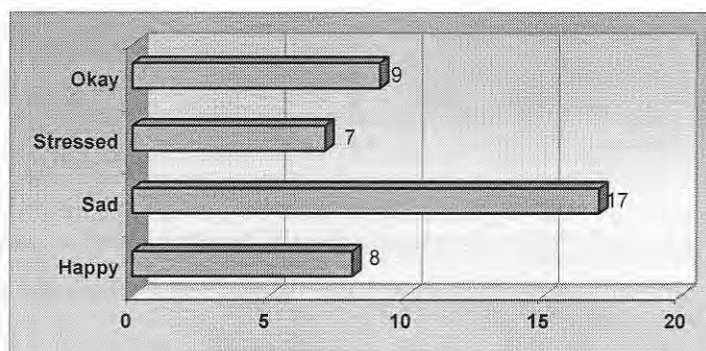


Figure 3: (CHECK NUMBERING.) Report on Feelings in General

Examples of typical responses on emotions:

#### Sad

*My father died and I had a lot to ask him and now my mother is also dead and I have no one to talk to and now my younger brother doesn't want to go to school.*

Male, 18 years old (Form 5), caring for five younger siblings

*There's no one to help us with food and other things, I wish I had a mother to help me.*

Female, 15 years old (Grade 5), caring for five younger siblings



**Happy**

*I take care of myself, I never mind about the situation because it's too late to change the situation. Anyway, I'm about to complete school.*

**Male, 19 years old (Form 5), caring for one younger sibling**

*I feel happy because I have my friends at school that I talk and laugh with*

**Female, 16 years old (Form 3), caring for two younger siblings**

**Stressed or Over-whelmed**

*When I get home I feel stressed thinking about what we are going to eat and when I have to study we don't have candles.*

**Female, 18 years old (Form 3), caring for one younger sibling**

*Most of the time the children want a lot of things that I cannot provide and they demand a lot from me.*

**Female, 19 years old (Form 5), caring for three younger siblings**

**Okay**

*I'm used to the life I am living now it doesn't bother me anymore.*

**Male, 18 years old (form 1), caring for three younger siblings**

*I try not to be involved in everything bad happening around, I exclude myself.*

**Male, 16 years old (Form 4), caring for two younger siblings**

When asked about social activities, 23 of the children who completed the questionnaire reported not having access to social facilities, whilst 32 reported belonging to a social group. Of the 18 who reported having access to social facilities most were boys. The social groups children reported belonging to ranged from school teams (2), church groups (24), and a few community groupings (6). Just over half of them (54.55%) reported participating in their social group only once a week, followed by seven (21.21%) of them participating twice a week, and five (15.15%) participating three or more times a week.

Issues of abuse in these types of households are not widely looked at in the literature; abuse is often alluded to but never fully explored. Owing to the sensitive issues surrounding this type of respondent (children and adolescents), the issue of abuse in this study was only lightly touched upon. A few questions around feelings of abusive treatment by adults and how they coped with it were asked. Of the 41 respondents 12 children reported that they had felt mistreated by adults. Of those, only half reported this abuse to anyone. When asked the reasons why they had not reported this treatment four of the responses were based on fear because the abuser was a person in authority, a family member (3), or a community member (1). One child responded that she was simply afraid to report the abuse committed against her but would not disclose why,

whilst another stated that he didn't feel the need to report abuse because he could take care of himself.

A key factor in the issue of community support for these CHHs is the attitude towards the children by community as perceived by the children themselves. Children were asked whether they felt accepted in the community. The majority of the children felt welcomed in their community while three displayed a feeling of ambivalence towards the community in which they lived.

Typical reasons for feeling welcomed were when respondents reported they were allowed to interact with or were helped, or encouraged by members of the community. Reasons for feeling unwelcome in a community centred, as expected, around issues of trust and community not taking an active interest in their and their siblings' welfare. A surprise was the low number of children who did not have a definitive feeling about whether they felt welcomed or not.

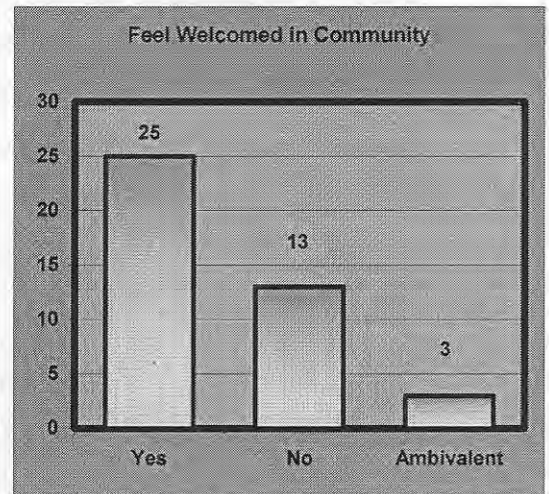


Figure 4: Feel Welcomed by Community

The researcher would have expected the number

of "ambivalent" responses to be higher because of her assumption that most of these children would feel that they were not in a powerful position because of the absence of an adult protector. Three children fit this category:

Responses of those who felt ambivalent about their communities

Child #1: *They don't help and they don't do anything bad*

Child #2: *We live here; there is nothing we can do*

Child #3: *They've given us a place; I can't think about that [feeling welcomed or not]*

## 4.5 Government and NGO Programmes: Knowledge and Usage

### 4.5.1 KaGogos and NCPs

Since there were institutions already in place for orphans and vulnerable children to go and get their needs met, the researcher wanted to find out if the children in this area were accessing or had even heard of these facilities. When asked about the KaGogo and NCP feeding and care centres most of the children (58.54% or 24 children) interviewed had heard of them although most of those had never used them (79.17% or 19 children). Of

the five who had used these facilities four felt they had been assisted while the fifth felt he had not.

The ways in which the four felt they were assisted were by being given foodstuffs when they got there such as maize and beans and some were given maize seeds for planting. One of the respondents, a 16-year-old boy, expressed feeling disappointed when he went there because he was expecting a 20 kg of maize and only got a 2.5 kg bag of beans. Another 19-year-old girl reported that although she had not gone, her younger brothers did and they informed her that they had been allowed to eat until satisfied.

The remaining children who knew of but had not utilised these places were asked their reasons for not attending. The reasons centred on four main themes: (1) not invited to join; (2) do not know location or (3) location too far to travel and (4) did not understand the purpose of the facility and therefore didn't see the need to go.

#### **4.5.2 Lelikalela Lelihlombe (LL)**

In the case of the "shoulder to cry on" there was even less of a response, which demonstrates a lack of investment in the psychosocial support for these children. Of the 41 respondents, 24 had heard of the LL, but only two had ever used them. Positively, these two children had felt assisted by the LLs they saw. When the other children were asked why they had not used the LLs, the reasons centred on (1) not feeling abused; and (2) not thinking they could be helped by the LL. These individuals, despite knowing about the facilities, do not feel confident that their needs will be met at these facilities.

#### **4.6 Urgent Needs**

All participants were asked to describe what they felt their most pressing needs were. The list in order of most expressed need was as follows:

1. Food (39 children)
2. Clothing (33 children)
3. School funds (17 children)
4. Shelter or building materials (10 children)
5. Toiletries (5 children)
6. Medical Aid (2 children)
7. Water (2 children)
8. General care assistance (1 child)

The only way to truly understand these households' needs is to ask the children living in them directly; this was the purpose in finding out what they felt their needs were. It was interesting to note the thing that is obvious yet minor and therefore often taken for granted: toiletries.

## Part 5 – Discussion



Child (centre), with neighbours, belonging to a family headed by her 16 year old sister

### **5.1 Introduction**

Human development is something that any government understands the importance of and we cannot stand back and hope for the best. Children who are made vulnerable early on in their lives are likely to be impacted negatively throughout their lives and so it is important to assist them in overcoming whatever hurdles have been set before them. This chapter discusses the findings and limitations of the study.

### **5.2 Discussion**

Families and communities are the first line of response to the phenomenon of CHHs. Children who lack access to health care, education and security will also lack the power to contribute to family and community. Children's participation in policy and programmes that concern them directly should be encouraged, not only by Government, but also by the international and national organisations that are there to assist them. The Convention on the Rights of the Child states that any decisions affecting a child must only be considered in light of what are the best interests of the child. When the child in question is the head of household and caregiver to siblings, this issue becomes a little more complex.

Often times, the HHs have formulated their own social networks to support themselves and their siblings; usually these networks work. It is important to examine the coping strategies of these children and work from that base. The case of Mandla (see Case Story 2 below) is an example of the coping strategies that can work for these children.

### Case Story 2:

Mandla is 19 years old and in his last year of high school. Mandla tells of how he tries not to be too dependent on others to sort out his problems. His school is far from home so he can't make it home everyday to check on his two younger sisters, a 17-year old and a 10-year old. His home is his parental one; he stated that when his father died there was a problem within the family because his uncles wanted to take over the property. Luckily for Mandla, a family friend stepped in and reported it to the local Chief and the matter was resolved. During school holidays Mandla works as a bus conductor and earns between E300 – E450. But during school days he depends on family friends and WFP for food and other necessities. Tibiyo pays half of his school fees while he negotiates a payment scheme for himself for the other half. Some teachers at the school assist him with bus fare for the commute home and friends help him with school textbooks. When asked about his health he reported going to hospital in the last month because he had headaches, memory problems and loss of appetite. There they informed him that it was stress related. He agrees that is probably what it was because he generally feels overwhelmed by all his responsibilities and he can't always cope with the situation. When asked if he feels welcomed in his community he stated that he doesn't because the neighbours "don't take care of my sisters when I'm away. I find them in a poor state whenever I get back home." Mandla said that he had heard of the KaGogo's, NCPs but he and his siblings never used them because "they care for young children between the ages of 3 and 10 years (old)." When asked if he has ever used a LL for psychological support he stated, "I don't think they can help because there is an issue of not knowing how they are chosen and they don't go to the families." Instead Mandla prefers to talk it out with a friend when overwhelmed.

According to the UN Framework<sup>33</sup> for assisting orphans and other vulnerable children, there are five key strategies for responding to the needs of OVC. These are:

- Strengthening the capacity of families;
- Mobilizing and Supporting community-based responses;
- Ensuring access for OVC to essential services;
- Ensuring governments protect vulnerable children through improved policy and legislation and through channelling of resources to families and communities; and
- Advocacy and social mobilisation to create a supportive environment for OVC

To help the children in these types of households it is important to accept that they can be quite viable and the fact that 26 (63.41%) of the children did receive some kind of

assistance from a family member indicates that the family networks are still there. Children's choices need to be respected and their opinions taken into account about why they may want to continue living in this type of situation. Studies have found that CHHs are formed for various reasons, including the children not wanting to be separated and not wanting to lose their family inheritance.<sup>34,35</sup> The problem is that these family networks are obviously stressed as indicated by the frequency by which the assistance is provided (nearly half, 48.78%, of the children received no assistance in the previous month). It is important to know who the supportive links are within the family in order to assess what they need in order to increase and sustain the support. The high stability of living environments for this group of children is a good indication that there were not too many issues surrounding property grabbing by relatives. A majority (65.85%) of the children had been living in their current home for six or more years. This low migration rate allows for the development of continuous programmes targeted at these child-headed families such as life-skills strengthening (including mentorship) and economic activities. Children must be given a voice in all activities that will have an impact on their lives. Child heads of household are thrust into situations where they assume many different types of roles and skills in order to cope, such as leadership, decision-making and care giving, which can be very stressful.<sup>36</sup> The point must be stressed that each child-headed household is as distinctive and individual as the children who live within it. It is therefore important to find out from the children themselves what their unique needs are in order to better support them.

Many projects are often child-focused without being child-centred. Often NGOs and other well-meaning groups do for the child rather than with the child. This can lead to even more disrupting circumstances within the child's life. Nozipho's story (see story case 16 in box) illustrates how even when a child seems to be getting assistance on the face of things, there are usually other stressors that play a role in his or her life. Lessons learned from a study on CHHs in Uganda stated that it is important to support families and individuals and to give care while not destroying the children's vital coping strategies.<sup>37</sup> This means that in the case of Nozipho (see case story below), it would have been more effective for the assisting organisations to find out what her family support structure was and what would be more conducive to harmonious living. Not consulting or at least alerting the supportive uncle about the chickens or goat fund that WV supplies to OVC caused Nozipho and her sibling to have to fend for themselves. This is just an

example of how an NGO could have strengthened family ties and unwittingly played a role in weakening them.

**Case Story 16:**

Nozipho is an 18-year-old student who is in form four. She cares for her 16-year-old brother who is in form 3 and the two both lived with their 20-year-old brother who recently dropped out of school because of a lack of school fees. He has now left home to go and look for work to support his siblings. In the meantime Nozipho has to figure out how to run her home. Nozipho and her younger brother used to live with an uncle until problems arose because World Vision had given her money to buy chickens and he got upset about this and said he doesn't want chickens around his house and that the children should leave. Nozipho and her brother returned to their parental home. Her stepmother stays in another town and is currently ill so Nozipho is expecting her two half-siblings to come and live with her soon. She recently had to go and negotiate school fees payments for her half-siblings because the mother was too ill to go herself. Her uncle still assists each month with the payment of their bus fare for school. Caritas, a local FBO, assists with beans and maize-meal each month, but Nozipho complains that they usually run out of food before the end of the month.

During the conducting of this study, the researcher was informed by a community member that one of the problems that arise in the care of these CHHs is the habit of many community members viewing the "wealth" of the children by outside appearances. Most of the children in this study lived in unsatisfactory living conditions. Several (9) complained that their homes were cold and when it rained water would drip into their home. A limitation of the study was that the researcher was not able to go to all the houses and view them personally, but it is the children's opinion of their home that is important in the end. World Vision is one of the few organisations that is responding to this crisis and the researcher found two homes that had been built by them. In one area a local businessman has built a few homes for children living in child-headed families and provides food for some. When parents die and leave them in better built homes than those of the neighbours, the community tends to be reluctant to offer assistance despite recognising that they are still school aged and have no source of steady income. The example in Case Story 15 below illustrates this point.

### Case Story 15:

Sindi, a 16-year-old girl, is living with her 18- and 24-year-old brothers. The elderbrother is being treated for TB. He is currently doing casual work assisting a community member build their home. The duties of running the household seem to have automatically fallen to her simply because she is the girl. Their home is a modern brick, three-bedroom home, that does not have electricity or water since their oldest brother passed away a few years ago. This brother was employed and acted as protector of their inheritance when their parents died; he stopped the extended family from taking their cattle and home. Sindi and her siblings suspect that extended family had something to do with his death. After his death and the subsequent loss of income, the siblings asked the extended family for assistance. They were told to sell off the cattle and some of the household items. Sindi states that she feels welcome in her community [but her older brother contradicts this saying that whenever something goes missing at their neighbours' residence theirs is the first house to get the blame simply because they are without adults here]. She describes feeling stressed often because her brothers come home "demanding" food from her when there isn't any. An NGO used to provide them with beans but has not been around in a while and she is not sure why. When it comes to accessibility to water Sindi reveals that her neighbours charge her and her siblings E30 to get water from their tap.

The case of Sindi and her brothers is interesting in that there is a sense of contradictory feelings from the neighbours who feel the children are well off enough to be able to afford to pay for the water and yet are poor enough to steal from them. The lack of knowledge and understanding by the community and extended family of what CHH households have to go through perpetuates the vulnerability of these children.

Children were asked how welcomed they feel in their communities and their responses seemed to correlate directly with the amount of support they received from neighbours. Most of the children felt welcomed because neighbours supported them in some manner (emotionally and physically). A significant number of children felt they were not welcomed as result of mistrust (possibly mutual in many cases, as indicated by Sindi's story), and a lack of support. One 18-year-old boy stated that he did not feel welcomed because when he tried to attend community meetings he was sent away because he was considered too young to come. The irony is that this *child* is performing adult functions within a household that is essentially his. As noted in the literature review, Swaziland Government through NERCHA and other partners, is attempting to utilise community members in assisting with the care of vulnerable families (including CHHs). Should the Lutsango initiative prove to be a sustainable and expandable project, it would go a long way in assisting in the day-to-day running of CHHs, but there are concerns of over-bureaucratising the project. Women who initially volunteered to participate in this programme are now being offered regular wages and further research needs to be done



into what the consequences are of turning well-meaning community volunteers into paid employees.

Peer support plays a big role in the lives of these children as well. As the findings in this study demonstrate, children who felt happy were ones who felt that they were doing something for themselves and their siblings and those who had an emotional outlet, such as friends to “laugh with”. For many of the children in this study, church was the only social outlet that was available. Although that can be good, it can also be restrictive in some senses. Children need to laugh, play, dance and be loud. They need to move around and expand their minds in social places that bring them together with others their age who are from different background and experiences. There needs to be an investment into community centres or social areas within communities where children can go. It was found that mainly boys had social outlets (soccer fields), while girls had to wait for school to socialise.

The NCP and KaGogo centre are other potentially great initiatives that assist vulnerable children. During the course of this study the researcher was under the impression, due to what appeared in the literature that these centres were for *all* vulnerable children. It was later brought to her attention that the target group for these centres were under-6 year olds or non-school aged children. This is disturbing in light of the fact that so much money is invested in helping vulnerable children, but still a great number of needy children are being excluded from receiving aid, such as food. When this study asked the children whether they had heard of an NCP or a KaGogo over half (58.54%) indicated they had. Only five of those indicated ever using one of these centres and it was not clear if the majority of others had not tried to because they were not allowed to or because they simply saw no reason to. There is clearly lack of information about services that are available through caregiver centres such as these. Even if a child is not welcomed to the centre, they should have the information available to them at least for younger siblings.

The need for more food was reported to be the most urgent need by 95.12% of the children in this study. The justification for catering for non-school aged children has been that it gives those children a place to go when their older siblings are in school. The diet of the children in this study is a cause for concern. Obviously lacking were the dairy, meat, fruit, and leafy vegetable groups. Children require a very specific number of calories in order to develop to their fullest potential. Adolescents are particularly vulnerable nutritionally speaking for many reasons, including their high nutritional

requirements for growth, their susceptibility to environmental influences, and their eating patterns. Key micronutrient deficiencies can have a great negative impact not only in the present but in their adult lives as well. Zinc, which is found in red meats and whole grains, is important for growth and sexual maturation. Calcium is doubly necessary in the adolescent years as children begin their growth spurts. By age 17, adolescents have attained approximately 90% of their adult bone mass. Thus, adolescence represents a “window of opportunity” for optimal bone development and reduction of the lifetime risk of fractures and osteoporosis.<sup>38</sup> Iron is another key micronutrient necessity. Iron has been shown to play a role in HIV and TB, especially impacting on adolescent girls.<sup>15</sup>

The children in these households have maize meal, which is iron fortified, almost every time they have a meal. The introduction of the Indlunkhulu Fields initiative and SPTC (Swaziland Post and Telecommunications) and FAO monetary donations to establish gardens in the NCPs<sup>17</sup> are very important to the sustenance of children in need in different Swazi communities, particularly rural ones. There is an enormous lack of studies done on the health and nutrition of adolescents (the major age group of CHHs) in Africa and this gap must be filled in order to better comprehend this crisis. A comprehensive study needs to be done on the vitamin and micronutrient intake of vulnerable households in Swaziland, in order to better understand exactly what should be grown in these gardens. Swaziland also has many indigenous traditional leafy vegetables that grow in the wild. Children could be trained on how to identify them and pick and prepare them at home.

According to the new National Health Policy of Swaziland, 85% of the population lives within an eight-kilometre radius from a health facility.<sup>39</sup> The policy recognises that despite this, the quality and availability of health services is affected by distribution of resources which tends to favour urban over rural areas. In this study, access to safe water sources was minimal and sanitation facilities were limited. Despite this, these children seemed to be a relatively healthy group at the time of the interviews. The most positive finding in this study is that most of the children in this study do have access to basic health service facilities and medication when needed as indicated in their sources for health care. Very few either reported attending hospital for themselves or others (5) *in the last month* and not using medication when ill (4). The most worrying issue concerning health was how few of them had actually been visited by any kind of health personnel (17.09% or 7) and even fewer had ever been seen by a social worker (1). As worrying as this is, it is not shocking because the MoHSW has experienced its fair share of “brain

drain” alongside other countries in the region. Recently, there has been a move to revamp the MoHSW and particularly the Social Welfare Department by increasing the number of personnel needed to be more effective.<sup>20</sup> Until this request is granted by the Government, the utilisation of community members as RHMs becomes a mandatory “crutch” for the social worker in order to complete his/her responsibilities to these children. An essential aspect of this is coordination and partnership between the health and welfare departments in order to find, keep and assist CHHs. The concern is that there may be an over dependence on field workers, who are more than willing to help but have too resources to assist them complete the task. This lack of resources could lead to worker fatigue and eventual loss of continuity of care for the children as these RHMs have personal concerns too. What is significant about the lack of social worker visits is that these children are missing out on vital information regarding grants that they have access to. MoHSW should more fully engage the MoE when it comes to CHHs. School fees are important, but so are health issues surrounding this vulnerable group. Since schools already have lists of vulnerable children that attend, it would be appropriate to develop a program that would serve as source of information for children so that they know what resources are available to them by right. School therefore, becomes an important source of not only food and education but also other relevant information impacting on the health and livelihoods of these children.

Swaziland is steadily trying to work towards the Millennium Development Goals, specifically that of free universal primary education by 2015. Jones found that many children repeat years as they drop out due to a lack of school fees. Children in that study were often found to be two to three years over-age for their grade in school.<sup>40</sup> In the same study Jones noted that relationships between families and schools were damaged due to the MoE’s inefficiency in the distribution of funds for OVC. The majority (32) of children in this study were assisted at least partially by the Government. Tracking issues of delayed or non-payment of fees by Government in this study was not feasible for the obvious reasons that all the HHs reported being in or were found in school at the time of the interviews. Although there was no obvious concern regarding availability of school funding for children, it was hinted at in the list of immediate needs from the children’s perspective. School funding and educational needs was the third highest need mentioned by 17 children. Besides this, it was found that amongst the siblings three had failed the class they were in and were now sitting at home because nobody would or could pay for repetition of the class. Another two siblings simply could not afford to go to school. This

is disturbing in light of the fact that there are scholarships for OVC available. Programmes that help students from vulnerable households to maintain passable grades should be adopted as soon as possible. Children who come from these homes often have to contend with a lack of electricity and candles for studying, more often than not, they do not even have books to assist them at home. Of the siblings that were in school, 56.70% were still in primary school while 14.43% were in secondary school and 2.06% were in high school. Of the children who reported assistance with the provision of school uniforms and schoolbooks more had assistance from parents and other family members. More assistance from family in the case of uniforms may be because uniforms do not necessarily have to be purchased every year and are therefore less costly. Many textbooks can be rented from the school so this also proves to be less costly. Notably, some children reported that a parent or other family member had assisted with purchase of uniforms but now the uniforms were old (worn and small in size).

The necessity of education has been emphasized and must be repeated here. A few years back South Africa's president, Thabo Mbeki, made a statement about poverty causing HIV/AIDS. The researcher agrees, but feels he didn't go far enough; poverty perpetuates *all illness* in every successive generation. Unless these children get the education they need to be successful and reach their potential, they are left to the unforgiving whims of poverty and the cycle of poor children living in CHHs is likely to continue.

In Swaziland there is a problem with the ownership and integration of OVC issues into the national development planning programmes due to "overarching perceptions that this is a crisis intervention requiring external funding and implementation."<sup>41</sup> There seems to be a gap not only in national but international policy that permits whole segments of vulnerable children (particularly adolescents) to be unwittingly neglected. Much of the literature from statistical analysis and other studies on adolescents seem more concerned with the issues surrounding HIV/AIDS education and sexual reproduction. Whilst these are important areas to look at, adolescents are faced with many more issues that have nothing to do with sex and illness. Any attempt to examine and respond to other needs, such as hunger, self-esteem and shelter concerns, has been limited at best, especially for children who head households.

Advocacy by NGOs has played a huge role in revealing the plight of vulnerable children. The Government relies heavily on the NGO sector working within the country to educate the public and reach vulnerable children due to NGO grassroots level

networks. Organisations such as Family Life Association of Swaziland (FLAS) and School Health and Population Education (SHAPE) are vital role players in educating and sensitising the public to the plight of children (especially vulnerable ones) and their families, through advocacy work including workshops for community leaders and parliamentarians.<sup>42</sup>

One clear factor that cannot be excluded is the one of the status of women in Swaziland because of the impact their status has on children in these situations. Studies have shown that more mothers are likely to stay with their children on the death of the father than fathers stay with the children after the mother's death or absence.<sup>43,44</sup> In this study, there were a few cases of the mothers abandoning their children and starting new families elsewhere (five mothers compared to two fathers). This is an unexpected development and can only be explained by the social and economic disempowerment of women. Further study would have to be done to examine this phenomenon and look at whether economics are really the cause. Another cause of this abandonment of children by living parents could be simply the degeneration of family values (including the new man not wanting to care for another man's child).

This study has shown that cultural beliefs and tradition can play a big role in fuelling the vulnerability of CHHs. Cultural beliefs may have an impact on the psychosocial health and overall development of children, such as how a child believes a parent was killed, for example through witchcraft (three children believed this), and traditional habits of how men feel about rearing other men's children. In both cases, advocacy and education can play a positive role. An example would be getting men to be more empathetic with the plight of women and children in Swaziland by actively involving males in programmes. NERCHA, supported by ECHO, has been actively trying to get men involved in the issues surrounding HIV/AIDS in Swaziland.<sup>21</sup> It is hoped that there will be discussion surrounding children and the role that they as Swazi men play in the lives of children.

There have been developmental steps taken by country leaders in recent months; these include the previously mentioned parliamentary portfolio on child issues. Its significance is that this shows that Government is taking an active step at being more responsible to the plight of children in Swaziland. With children steadily making their way back onto the Swazi agenda, it is hoped that children themselves will be invited to share their experiences and opinions when it comes to creating future policy and programmes.

### **5.3 Limitations**

- Because the convenience sampling method was used to identify these children, it became difficult to visit the homes of all the children and get a first-hand look at their living conditions. Although this dependence on second-hand information was a limitation, it did lend itself to the advantage of getting the children's perspective on what they felt their own living conditions were like.
- Although this study reflects the awful circumstances that children in this type of situation have to endure, it cannot pronounce on the scale of the problem within the Siteki region. Given the lack of reliable figures, it is not possible to determine the proportion of orphan-headed households in Siteki.
- The size of the sample for this study (41) does not allow the results to be generalised to the wider population.
- The sample was selected from children who were in school, which quite possibly excluded some CHHs who are unable to attend school.

## **Part 6 – Conclusions and Recommendations**

### **6.1 Introduction**

This study examined a small section of what is a large Swazi and African phenomenon. It describes the living conditions of CHHs and reveals the incredible resilience of these families despite the odds. CHHs are extremely vulnerable because of the unique characteristic that sets them apart from other vulnerable families: the lack of an adult figure. It is essential they are assisted, protected, educated and allowed to develop to their potential. Only then can a society begin to hope to deal with the negative health and economic problems that are impinging upon its development processes.

### **6.2 Conclusion**

This report attempts to describe the health and living conditions of children in CHHs in the Siteki area of Swaziland. It also identifies the type of support that is needed by this vulnerable group. The primary caregivers in these households are between the ages of 15 and 19 years old. There is not enough focus on this group as caregivers. The literature and research do not concern themselves with older children despite these being the ones

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## **Part 6 – Conclusions and Recommendations**

### **6.1 Introduction**

This study examined a small section of what is a large Swazi and African phenomenon. It describes the living conditions of CHHs and reveals the incredible resilience of these families despite the odds. CHHs are extremely vulnerable because of the unique characteristic that sets them apart from other vulnerable families: the lack of an adult figure. It is essential they are assisted, protected, educated and allowed to develop to their potential. Only then can a society begin to hope to deal with the negative health and economic problems that are impinging upon its development processes.

### **6.2 Conclusion**

This report attempts to describe the health and living conditions of children in CHHs in the Siteki area of Swaziland. It also identifies the type of support that is needed by this vulnerable group. The primary caregivers in these households are between the ages of 15 and 19 years old. There is not enough focus on this group as caregivers. The literature and research do not concern themselves with older children despite these being the ones

who tend to be the majority age group in the households headed by children. There is evidence that they are not receiving adequate diet, physical and emotional support, or information on services that affect them and their siblings.

This study showed that community and familial networks were still intact for many of the children, although there was evidence that they were highly stressed as indicated by the infrequency of support. Most children felt welcomed in their communities and this indicated that they did not feel stigmatised by neighbours and were likely to be supported by them in some way. Of concern were the few children who did not feel this way, mainly due to the mistrust of neighbours' intentions towards them.

Most children in this study were found to be physically healthy at the time of interviewing them and had satisfactory knowledge of where to go to get medication and healthcare without too much trouble. What was of concern was the lack of access to social services. Only one child had ever been visited by a social worker and that was for her grandmother who had since passed away. The living conditions of the children were generally poor, as reported by the children themselves, which was to be expected. Holes in living structures, unsafe water sources and lack of sanitation facilities all lead to this conclusion. Another concern is the diet and nutrition of these families.

On the positive side, they receive food through the school feeding programmes and some receive food donations by NGOs every so often. The lack of variety in the food of these growing children is cause for concern, particularly the lack of meats, dairy and fresh fruits and vegetables. Children, especially adolescents, have very specific vitamin and micronutrient needs at this stage in of their lives and these are not being adequately met. Negatively, there were numerous complaints of food running out before the arrival of the next donation. There were also revelations of food stoppages from caregiver organisations without any reasons being given. The NGO working in the area at the time was approached about this and the researcher was given records showing the delivery of food to the locations stated. This inconsistency in information from donor to child may indicate another problem, that of a lack of communication between donors' head offices and their field offices and insufficient child participation through input from children and follow-up by donors. Many of the NGOs depend on community members to do the fieldwork. They set up committees and workgroups and hope that the training they supply is adequate. As evidenced in this report, children are left without information regarding services for food and social concerns. Children do not seem to be consulted about their needs. Not only would this communication with the children themselves allow



organisations to clearly identify what to give, but it would also allow children to understand their role in terms of aid provided to them.

Community-based projects were in evidence in the literature and children indicated knowledge of the social centres (NCPs and KaGogos). They were, however, ill informed about the services that these centres provide, such as psychosocial support and meals. There was knowledge of the psychosocial community workers (LLs) but there seemed to be a general lack of knowledge about the function of the workers. Many children reported not going to the LLs because they were not abused. The idea of the LLs only being available for abuse issues instead of for all psychosocial concerns, may be causing a barrier to relieving these children of other psychological issues. Positively, the Lutsango project has been working in some areas and with apparent success. There is a need to step up the delivery of this service as it obviously has not been as widespread and functional as hoped as none of the children in this study mentioned any assistance of the type provided by Lutsango.

There is a serious lack of coordination among Government, NGO and all other sectors that impact on the lives of vulnerable children. There is competition and a lack of communication between the ministries of health (and social welfare), education, youth and development and finance. National and international agencies such as NERCHA and UNICEF seem to be competing for the limelight on projects without coming to a single vision about caring for children. This study recognises that there is much good work going on at the ground level by smaller and much less funded organisations such as FLAS and SEBENTA (a vocational training organisation). But many of these organisations are struggling to keep their head above water so to speak because resources are not reaching them to continue their work at grassroots level. In the meantime, the vital RHMs and the vulnerable families, such as those of CHHs, are left to manage things as they can.

### **6.3 Recommendations**

- Training of more social workers by MoHSW. Government needs to ensure and prioritise the increase in social work and health personnel by offering scholarships for key health functions. It should ensure staff retention through programmes such as compulsory community service and Government internships for graduates.
- Deployment of social workers to schools and hospitals to improve the efficiency of the social welfare department. There is a vulnerability to abuse in this group

and more formal, regular visits from a social worker are mandatory. The schools are key places for the setting up of support services such as counselling and giving of information related to available social services.

- Recognize and encourage individual (private sector) goodwill, but do not over-formalize (e.g the turning in of paperwork by donor, takeover of projects or programmes by Government or royal offices, as has been done in the past) it thereby killing the initiative of these individuals and organisations.
- Provision of free primary school education to enable more children to attend school where they can learn life-saving skills and improve human capital for the country. Although free primary school access is already in progress, it has been slow to roll out and, as the years go by, many children lose motivation and opportunity.
- Monitoring and evaluation of care services in all communities. This is something that must be performed by both Government and other agencies that provide care to children. Community workers are indispensable for assisting with the “dirty work” of delivery, but donor organisations should ensure that all children are being cared for, even if it means “spot checks” every so often.
- Creation of a system whereby children are registered as living in CHH and healthcare and access is provided freely. That same system could be used to monitor these households as older siblings leave and younger ones are carried through.
- The well being of these children is something that cannot be looked at only during the time of their schooling; aid to these households must continue even after the HH has graduated from high school.
- Children need to be actively involved in the early stages of program planning and community planning that will affect their lives. There should be mechanisms in place that ensure child participation (for example, community meetings specifically for youth) and it should be enforceable by Government (law and policy).

- A detailed nutritional assessment needs to be done to investigate the vulnerability of these households.

#### **6.4 Future Research**

- Survey to determine the size of the problem of CHHs in Siteki and Swaziland.
- Deeper analysis into the vulnerability and extent of physical and emotional abuse.
- Research into the reasons that parents in Swaziland are leaving their children behind to head households in order to assess how families may be strengthened.
- Investigation into the health indicators of these children (morbidity, mortality, etc) as compared to other children.
- Research into the educational performance of children from CHHs – how well do they perform, why or why not?
- Study on child-friendliness of health facilities: are children generally healthy or are they just refusing to go to clinics?
- Participation study on children’s perspective on the degree to which they feel they are being actively involved with aid organisations that target their needs.
- Community members’ attitudes towards children in CHHs to gauge the degree to which they feel responsible for caring for them.
- A study on the effect of changing a volunteer community-based initiative such as Lutsango into a paid position organisation especially in the Swazi context.

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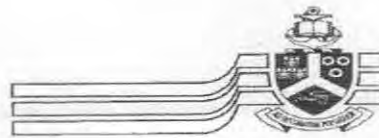
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# APPENDICES

## APPENDIX A: Approval letter from University of Pretoria Ethics Committee



University of Pretoria

Faculty of Health Sciences Research Ethics Committee  
University of Pretoria  
Tel: (012) 339 8619 Fax to E-Mail: 086 6516047  
E-Mail: [deepeka.behari@up.ac.za](mailto:deepeka.behari@up.ac.za)  
Date: 22/11/2006

Soutpansberg Road  
MRC Building  
Room 2 - 20

Private Bag x 385  
Pretoria  
0001

**Number** : S203/2006

**Title** : The health and living conditions of children in child-headed households in Siteki, Swaziland

**Investigator** : S S Eamshaw, School of Health Systems and Public Health, University of Pretoria  
(SUPERVISOR: DR Z NJONGWE)

**Sponsor** : None

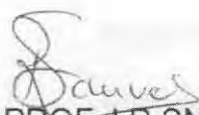
**Study Degree** : Master of Public Health

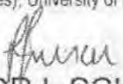
**This Student Protocol has been considered by the Faculty of Health Sciences Research Ethics Committee, University of Pretoria on 21/11/2006 and found to be acceptable.**

|                       |  |
|-----------------------|--|
| Mr K P Behari         | B.Proc. KZN; LLM – Unisa; (Lay Member)                                   |
| Advocate AG Nienaber  | (female)BA(Hons) (Wits); LLB; LLM (UP); Dipl.Datametrics (UNISA)         |
| Prof V.O.L. Karusseit | MBChB; MFGP (SA); M.Med (Chir); FCS (SA); Surgeon                        |
| Prof M Kruger         | (female) MB.ChB.(Pret); Mmed.Paed.(Pret); PhD. (Leuven)                  |
| Dr N K Likibi         | MB.BCh.; Med.Adviser (Gauteng Dept.of Health)                            |
| Dr F M Mulaudzi       | (female) Department of Nursing   |
| Mrs E.L. Nombe        | (female) B.A. CUR Honours; MSC Nursing – UNISA (Lay Member)              |
| Snr Sr J. Phatoli     | (female) BCur (ELAI) Senior Nursing-Sister                               |
| Dr L Schoeman         | (female) Bpharm, BA Hons (Psy), PhD                                      |
| Prof J.R. Snyman      | MBChB, M.Pharm.Med; MD: Pharmacologist                                   |
| Dr R Sommers          | (female) MBChB; M.Med (Int); MPhar Med;                                  |
| Prof TJP Swart        | BChD, MSc (Odont), MChD (Oral Path) Senior Specialist; Oral Pathology    |
| Prof C W van Staden   | MBChB; Mmed (Psych); MD; FTCL; UPLM; Dept of Psychiatry                  |
| Dr AP van der Walt    | BChD, DGA (Pret) Director, Clinical Services, Pretoria Academic Hospital |

### Student Ethics Sub-Committee

|                  |   |
|------------------|---|
| Mrs E Ahrens     | (female) B.Cur  |
| Dr L Schoeman    | (female) Bpharm, BA Hons (Psy), PhD   |
| Dr R Sommers     | SECRETARIAT (female) MBChB; M.Med (Int); MPharMed   |
| Mrs N Lizamore   | (female) BSc(Stell), BSc (Hons) (Pret),MSc (Pret) DHETP (Pret)  |
| Prof R S K Apatu | MBChB(Legon); PhD(Cambridge)  |
| Dr S I Cronje    | DD (UP) – Old Testament Theology  |
| Dr M M Geysler   | (female) BSc; MBChB; BSc HONS (Pharm); Dip PEC; MpraxMed  |
| Dr D Millard     | (female) Bcur LLB LLM LLD (UJ)  |
| Dr A M Bergh     | (female) BA ( <i>cum laude</i> ), Rand Afrikaans University BA (Hons) (Linguistics),<br>University of Stellenbosch Secondary Education Diploma ( <i>cum laude</i> ), University of<br>Stellenbosch BA (Hons) (German) ( <i>cum laude</i> ), University of South Africa (Unisa)<br>BEd (Curriculum Research and Non-formal Education) ( <i>cum laude</i> ), University of<br>Pretoria PhD (Curriculum Studies), University of Pretoria |

  
PP  
**PROF J.R. SNYMAN**  
MBChB, M.Pharm.Med; MD: Pharmacologist  
CHAIRPERSON of the Faculty of Health Sciences Research  
Main Ethics Committee - University of Pretoria

  
**DR L SCHOEMAN**  
Bpharm, BA Hons (Psy), PhD  
CHAIRPERSON of the Faculty of Health Sciences Research  
Students Ethics Committee – University of Pretoria



### APPENDIX B: Approval Letter from Ministry of Health and Social Welfare (Swaziland Government)

104-13-2006 01:06PM FROM-MINISTRY OF HEALTH

+268 4042092

T-527 P.001

F-891

November 7, 2006

In regards to: Request for consent to conduct the following study in Siteki

Mr. Eric Maziya  
Department of Health and Social Welfare Services  
Swaziland

Dear Mr Maziya:

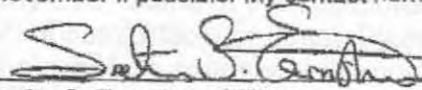
My name is Samantha Earnshaw and I am a Master's in Public Health (MPH) student at the University of Pretoria In South Africa. In order to fulfil the requirement for MPH I must conduct a research project. I have chosen to do my research in an area that will benefit both me and Swaziland, in particular the region of Siteki.

The study will identify the health and social conditions of children living in child-headed households and will give an indication of the size and nature of the challenges and will also enable relevant agencies to address these from an informed position.


Currently, the Faculty of Health Services (U.P) Research Ethics Committee is considering the protocol for this research. The protocol is available should you require this. I trust you will support this study as we have discussed this in previous conversation. I have attached the consent form created to show that the rights of these children will be protected.

The details for the research project implementation will be discussed with you at a later date once you have agreed in principle to this study. My request is for you to please sign and fax this letter back to me at (09 27) 12 841 3328 by Friday 10<sup>th</sup> November if possible. My contact number is (09 27) 72 601 0072.

Respectfully,

 (Student)

Samantha S. Earnshaw (MPH)

 (Research Supervisor)

Dr Zola Njongwe (Senior Lecturer)

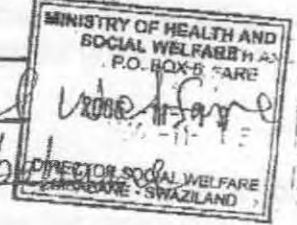
I, ERIC MAZIYA, representing the Department of Health and Social Welfare, Siteki District,  consent  do not consent  consent with conditions (please circle appropriate response) to this request.

Signature: 

Designation: Director Social Welfare

Date: 13/11/06

Place: Mb



## APPENDIX C: Assent Form for 10 – 18 Year Olds

### **Health and Living Conditions of Children in Child-Headed Households study (2006)**

My name is Samantha Earnshaw, a student at the University of Pretoria. I am required to do research as part of my studies. I am asking you to take part in this study so that the Department of Health and Social Welfare plus other governmental departments and non-governmental organisations will know what your needs are and be able to help homes like yours where children are taking care of other children.

#### *STUDY TITLE:*

The Health and Living Conditions of Children in Child-Headed Households.

#### *INTRODUCTION:*

You are being asked to assist us in this research study. This form is to help you to understand what it is about and choose if you would like to take part or not. If there is anything you do not understand about this information please do not be shy about asking the researcher for help.

#### *PURPOSE OF THE STUDY:*

Your home has been chosen as a possible participant on a study that is looking at how children who live alone are able to get by on a day-to-day basis. We hope to be able to see what the needs are for a home that someone of your age is in charge of. We will then pass that information to the government departments that may be able to help you, if you need help.

#### *DURATION OF STUDY:*

If you agree to take part in this study, we will talk together for about 1 hour.

#### *YOUR RIGHTS AS THE PARTICIPANT:*

It is your choice to take part in this study. You can say no if you want to or you can stop our talk at any time. Some of the questions asked are very personal and may cause you to feel uncomfortable or upset. Please understand that you also have the right to skip a certain question you are not happy answering. If you decide to stop our talk or just do not want to take part in this study, you will not be punished and nothing that was going to be given to you will be taken away. If you need help now, please tell the researcher and she will let the department that can help you know.

#### *BENEFITS OF THE STUDY:*

This study will allow government and other non-profit organisations to be better at helping your type of home. Please understand that the researcher will only pass the information on to the government and other helpful groups and she does not promise that they will use it.

#### *CONFIDENTIALITY:*

All information that will be gathered from you will be secret. Your name or your family member's names will not be told to anyone. By law the researcher is



required to tell you what she finds out from this study and she will try hard to make sure that you get this information.

Please make sure that you have fully understood everything that has been said before signing this form.

**ASSENT**

The researcher has told me what this study is about and how it will be used to help me. I also understand that I have the right not to participate in this study if I don't want to. I understand that my name and the names of my family members will not be used in any reports.

I can stop this talk at any time if I don't feel comfortable, without being afraid of being disciplined for withdrawing my agreement to take part in this study. I have been allowed to ask as many questions as I want to understand this study and (without being forced to) agree to take part in this study.

Participant's Name: \_\_\_\_\_  
(print)

Participant's Signature: \_\_\_\_\_

Researcher's Name: \_\_\_\_\_  
(print)

Researcher's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I, \_\_\_\_\_ hereby confirm that the above participant has been informed fully of what this study is about and how the information gained from it will be used.

Guardian/ Witness' Name: \_\_\_\_\_ (print)

Relationship to household/ Children: \_\_\_\_\_

Guardian/ Witness' Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Place: \_\_\_\_\_



**APPENDIX D: siSwati Version of Assent Form for 10 – 18 Year Olds**

**IMVUMO KuBANTFWANA LABANEMINYAKA LENG 10 KUYA 18**

Ligama lami ngu Samantha Earnshaw, longumfundzi eNyuvesi yase Pitoli. Kusweleke kutsi ngente lucwaningo loluyincenye yetifundvo tami. Ngicela kutsi ube yincenye yalolucwaningo khona litiko leTemphilo Nenhlalakahle kanye naletinye tinhlangotsi takahulumende kanye naletinye tinhlangano letingekho ngaphansi kwaHulumende titewutatisisa kahle kutsi tidzingo tenu tiyini batewukhona kusita emakhaya lafana nelakini lapho bantfwana banakekela labanye bantfwana.

***SIHLOKO SELUCWANINGO:***

Temphilo kanye Nenhlalakahle yebantfwana emakhaya lagadwe ngulabanye bantfwana.

***SINGENISO:***

Uyacelwa kutsi utewusita kulolucwaningo. Lelifomu lentelwe kukusita utewuvisisa lokutawentiwa ubese-ke uyakhetsa nangabe uyafuna kuba yincenye yalomsebenti noma cha. Nakukhona longakuvisisi kahle ngalomsebenti, ungasosaba kubuta, lolophetse lolucwaningo akunike lusito.

***UMGOMO WALOLUCWANINGO:***

Likhaya lakini likhetfwe kutsi libe yincenye yalolucwaningo loluhlolisisa kutsi bantfwana lasebahlala bodwana baphila njani lilanga ngelilangas. Setsemba kutsi kutawutfolakala kahle kutsi banatidzingo tini kulamakhaya lapho umuntfu longangawe angamele lelikhaya. Imiphumela yalolucwaningo itawubese yendluliselwa kuHulumende longabese uniketa lusito, naludzingekas.

***BUDZE BESIKHATSI SALOLUCWANINGO:***

Nawuvuma kuhlanyela kulolucwaningo, sitawukhulumisana nawe sikhatsi lesilihora linye.

***EMALUNGELO AKHO NAWENTA LOMSEBENTI:***

Utatikhetsela wena kwenta lolucwaningo. Ungasho kutsi cha nawungafuni noma usho kutsi sale siyekela inkhulumo. Nawungakuja bulisi umbuto lotsite ungasugalaja. Nawufuna kuyekela noma ungasufuni sanhlobo kwenta lomsebenti kute lotakujezisa futsi ngeke wemukwe lobekufute ukutfole. Nangabe udzinge lusito nyalo, ncono utjele umphatsi walolucwaningo khona atekwatisa luhlangotsi lweNhlango lengakusita.

***IMBUYISELO YALOLUCWANINGO:***

Lolucwaningo lutawusita Hulumende naletinye tiNhlango letingasebenteli inzuzo ekusiteni emakhaya lanjengalelakho. Kufute kuvakale kahle kutsi umcwaningi utawendlulisela umbiko walolucwaningo kuHulumende nakuletinye tinhlangano tekusita umcwaningi aketsembisi kutsi vele batawusebentisa.

***TIMFIHLO:***

Yonkhe imininingwane letawubutfwana kulokucwaningo itawuba yimfihlo. Ligama lakho nemagama emalunga emndeni wakho ngekhe abhabatwe kunoma

ngubani. Ngekwemtsetfo umcwaningi uphokelelekile kukutjela ngemphumela welucwaningo kantsi futsi utawetama ngemandla akhe onkhe kutsi uwutfole umbiko walolucwaningo. Ucelwa kutsi ube nesiciniseko sekutsi uyayivisisa yonkhe imininingwane yalokukhulunywe ungakasayini lifomu.

### IMVUMO

Umcwaningi ungitjelile kutsi lolucwaningo lungani futsi nekutsi lutawusetjentiswa kusita mine. Futsi ngiyevisisa kahle kutsi nginelilungelo lekungatimbandzakanyi nalomsebenti nangingafuni. Ngiyevisisa futsi kutsi ligama lami nemagama ebantfu bemndeni wami angeke asetjentiswe kulombiko.

Ngingayekelalengkulumo nomanini uma giva ngingakhululeki ngayo ngaphandle kwekwesaba kujeziselwa kutsi ngihociseleni sivumelwano sami sekusebenta lolucwaningo. Ngivumelekile kubuta imibuto noma mingakhi njengekufuna kwati kahle hle ngalolucwaningo (ngaphandle kwekucindzetelwa kuvuma kulwenta).

Ligama lalosebentako: \_\_\_\_\_  
(print)

Kusayina Kwalosebentako: \_\_\_\_\_

Ligama lwemcwaningi: \_\_\_\_\_  
(print)

Kusayina Umcwaningi: \_\_\_\_\_

Lusuku: \_\_\_\_\_

Mine, \_\_\_\_\_ ngenta siciniseko kutsi lesisebenti sitjeliwe ngalokuphelele kutsi lolucwaningo lukhuluma ngani nekutsi umbiko lophuma kulolucwaningo utawusita kuphi.

Ligama Lalongufakazi: \_\_\_\_\_ (print)

Buhlobo nelikhaya/ Nebantfwana: \_\_\_\_\_

Kusayina Fakazi: \_\_\_\_\_

Lusuku: \_\_\_\_\_ Indzawo: \_\_\_\_\_



APPENDIX E: Child-Headed Households Questionnaire (English Version)

UNIVERSITY OF PRETORIA, Questionnaire for a study on the Health and Living Conditions of Children in Child-Headed Households in Botswana (2006)

**DEMOGRAPHICS**

Age: \_\_\_\_\_ CONTACT: \_\_\_\_\_

Sex: Female  Male

1. How old are you? \_\_\_\_\_

2. How many brothers and sisters do you have? \_\_\_\_\_

3. How old are your brothers and sisters?  
(List in order of age from oldest to youngest)

4. How many other people live here? \_\_\_\_\_

5. Are there any elderly people living here? Yes ( ) No ( )

6. How many people sleep in the same room? \_\_\_\_\_

7. Is your mother still alive? Yes ( ) No ( )  
*(Please indicate age)*

8. When did your mother die? \_\_\_\_\_

9. Do you remember what happened? \_\_\_\_\_



UNIVERSITY OF PRETORIA: Questionnaire for a study on the Health and Living Conditions of Children in Child-Headed Households in Siteki, Swaziland (2006)

**DEMOGRAPHICS**

Area: \_\_\_\_\_

CONTACT: \_\_\_\_\_

1. How old are you? \_\_\_\_\_

2. Sex: Female: ( )

Male: ( )

3. How many brothers and sisters do you have? \_\_\_\_\_

4. How old are your brothers and sisters?

(Go to grid on Education - page8)

5. How many other people live here? \_\_\_\_\_

6. Are there any elderly people living here? Yes ( ) No ( )

7. How many people slept here last night? \_\_\_\_\_

8. How many people slept here last Saturday? \_\_\_\_\_

9. Is your mother still alive? Yes ( ) No ( ) Don't know ( )  
(If yes, skip to 9c)

10. Is your father still alive? Yes ( ) No ( ) Don't Know ( )  
(If yes, skip to 10c)

9a. When did your mother die? \_\_\_\_\_

10a. When did your father die? \_\_\_\_\_

9b. Do you remember what happened? \_\_\_\_\_

10b. Do you remember what happened? \_\_\_\_\_

### DEMOGRAPHICS (continued)

9c. Where is your Mother? \_\_\_\_\_

10c. Where is your father? \_\_\_\_\_

9d. Is she well? Yes (  ) No (  )

10d. Is he well? Yes (  ) No (  )

9e. Is she working? Yes (  ) No (  )

10e. Is he working? Yes (  ) No (  )

### SOCIO-ECONOMICS

#### SHELTER/HOME

##### 11. Physical Description of Shelter:

11a. Floor: Mud: (  )

11b. Roof: Thatched: (  )

Cement: (  )

Zinc: (  )

Other: (  )

Tiled: (  )

Other: (  )

11c. Walls: Mud: (  )

11d. Total number of rooms: 1: (  )

Stone: (  )

2: (  )

Brick: (  )

3: (  )

Cement: (  )

4 or more: (  )

**SOCIO-ECONOMICS (continued)**

*HOUSEHOLD*

12. How long have you been living here? \_\_\_\_\_
13. Whom does this house belong to? \_\_\_\_\_
14. Are there any siblings that are **not** currently living with you? \_\_\_\_\_
15. Where do they stay? \_\_\_\_\_
16. Are there any ill people that you are looking after right now? (Whom?) \_\_\_\_\_

*SUPPORT/INCOME*

17. Do you have any relatives that assist you? \_\_\_\_\_
18. How do they help? \_\_\_\_\_
19. How many times in the last month have they come to give you help? \_\_\_\_\_
20. Do you do any kind of work to earn money? \_\_\_\_\_
21. Where do you work? \_\_\_\_\_
22. Do you get any assistance from government? \_\_\_\_\_
23. Do you get any assistance from anywhere else? \_\_\_\_\_
24. What kind of assistance do these give? \_\_\_\_\_

### SOCIO-ECONOMICS (continued)

25. Who provides clothes and food? \_\_\_\_\_  
 (If not provided by those mentioned above)

26. How much money do you get a month? \_\_\_\_\_

27. Who gives this to you? \_\_\_\_\_  
 (If not from employment)

### EDUCATION

| Children   | Age | Sex<br>(M / F) | School<br>(Yes /<br>No) | Grade | Work |
|------------|-----|----------------|-------------------------|-------|------|
| House Head |     |                |                         |       |      |
| 2          |     |                |                         |       |      |
| 3          |     |                |                         |       |      |
| 4          |     |                |                         |       |      |
| 5          |     |                |                         |       |      |
| 6          |     |                |                         |       |      |
| 7          |     |                |                         |       |      |
| 8          |     |                |                         |       |      |
| 9          |     |                |                         |       |      |
| 10         |     |                |                         |       |      |

### EDUCATION (continued)

28. Do you attend school? Yes: ( ) No: ( ) Sometimes: ( )

29. How do you get there? Walk: ( ) Bus: ( )

29. What Grade are you in? \_\_\_\_\_

Car: ( ) Other: ( )

30. If you do not attend school, why not? \_\_\_\_\_

31. When did you stop attending? \_\_\_\_\_

32. Do your siblings attend school? What grades?  
(Use above table to answer)

33. Who pays for school fees? \_\_\_\_\_  
\_\_\_\_\_

32a: Uniforms? \_\_\_\_\_

32b. School books?

### HEALTH

33. Have you been ill in the last month? Yes: ( ) No: ( )

34. If yes, what was the matter? \_\_\_\_\_

35. Have any of your siblings been ill in the last month? Yes: ( ) No: ( )

36. Who?

i. \_\_\_\_\_

ii. \_\_\_\_\_

iii. \_\_\_\_\_

iv. \_\_\_\_\_

36a. What was the matter?

i. \_\_\_\_\_

ii. \_\_\_\_\_

iii. \_\_\_\_\_

iv. \_\_\_\_\_

**HEALTH (continued)**

v. \_\_\_\_\_

v. \_\_\_\_\_

36b. What did you do?

i. \_\_\_\_\_

ii. \_\_\_\_\_

iii. \_\_\_\_\_

iv. \_\_\_\_\_

v. \_\_\_\_\_

*ACCESS TO HEALTH SERVICES*

37. Have you ever gone to the hospital/clinic for yourself or anyone in your home? Yes: ( ) No: ( )

(If the answer is no, proceed to question 40)

38. How long (minutes) does it take you to get to the hospital? \_\_\_\_\_

39. How do you get to the hospital/clinic? Walk: ( ) Bus: ( ) Other: ( )

40. When you or your siblings are ill, where do you get medicine? \_\_\_\_\_

41. Has anyone from the Department of Health visited your home in the past 6 months? \_\_\_\_\_

42. Has a social worker visited your home in the last 6 months? Yes ( ) No ( )

**HEALTH (continued)**

42a. If "yes" what was the visit about? \_\_\_\_\_

43. Do you know where the Social Welfare office is in this area? Yes (\_\_\_\_) No (\_\_\_\_)

*DIET*

44. What did you eat for breakfast yesterday? \_\_\_\_\_

45. What did you eat for lunch yesterday? \_\_\_\_\_

46. What did you eat for dinner yesterday? \_\_\_\_\_

47. Is this what you eat most of the time? Yes: (\_\_\_\_) No: (\_\_\_\_)

47a. If not, please explain. \_\_\_\_\_

48. Are you and your siblings satisfied with the amount you eat at each meal? Yes: (\_\_\_\_) No: (\_\_\_\_) Sometimes: (\_\_\_\_) Most Times: (\_\_\_\_)

*Questions 49 (including a and b) and 50 are if there are any children under the age of 2 years in the house.*

49. What do you feed the baby? \_\_\_\_\_  
(\_\_\_\_)

49a. Is that the usual food (s)he eats? Yes: (\_\_\_\_) No:

49b. If not, please explain. \_\_\_\_\_

50. Who helps you care for the baby? \_\_\_\_\_

## HEALTH (continued)

### *WATER AND SANITATION*

51. Where do you get your water? \_\_\_\_\_
52. How often do you get it? \_\_\_\_\_
53. How much do you get? \_\_\_\_\_
54. What do you use it for? \_\_\_\_\_
55. Do you have a toilet here? \_\_\_\_\_
56. What kind? Flush: ( ) VIP: ( ) Bush: ( ) Other: ( )
57. What do you use to cook food? Gas: ( ) Wood: ( ) Electric: ( ) Other: ( )
58. Where do you usually throw away your rubbish? \_\_\_\_\_

### URGENT NEEDS

59. What do you consider to be your most important needs right now? \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



## HEALTH (continued)

### *GOVERNMENT AND NGO PROGRAMS*

60. Have you ever heard of the Neighborhood Care Points or KaGogo's? Yes: ( ) No: ( )

61. If "yes" have you ever been to one? Yes: ( ) No: ( )

62. Did you feel that you got a lot of help when you went there? Yes: ( ) No: ( )

62a. Please explain. \_\_\_\_\_  
\_\_\_\_\_

63. Have you heard of "Lelihlombe lelikalela" in your area? Yes ( ) No ( )

64. Have you ever gone to this person for help? Yes ( ) No ( )

65. Did he / she help you? Yes ( ) No ( )

65a. Please explain. \_\_\_\_\_  
\_\_\_\_\_

**HEALTH (continued)**

*PSYCHOSOCIAL SUPPORT*

66. How do you feel most of the time? Happy (\_\_\_\_) Sad (\_\_\_\_) Angry (\_\_\_\_) Stressed or Overwhelmed (\_\_\_\_) Other (\_\_\_\_)

66a. Please explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

67. Do you know anyone that you can talk to freely when you need to? \_\_\_\_\_

68. Are there any areas in your community where you can play or get together with other people of your age group? Yes (\_\_\_\_) No (\_\_\_\_)

69. Do you belong to any social groups (such as youth groups, church groups, community groups) in your area? Yes (\_\_\_\_) No (\_\_\_\_)

70. If the answer to question (69) is "yes" which ones? \_\_\_\_\_  
\_\_\_\_\_

71. How often do you join in these activities in your area? \_\_\_\_\_

72. Has an adult ever treated you in a way that made you feel uncomfortable, angry or sad? Yes (\_\_\_\_) No (\_\_\_\_)

**HEALTH (continued)**

73. Did you talk to anyone about this? Yes (\_\_\_\_) No (\_\_\_\_)

73a. Please explain (why or why not). \_\_\_\_\_  
\_\_\_\_\_

74. Do you ever feel like you are not welcome in your community? Yes (\_\_\_\_) No (\_\_\_\_)

74a. Please explain. \_\_\_\_\_  
\_\_\_\_\_

This concludes the interview. Thank you so much for your time.