CHILD HEADED HOUSEHOLDS: IDENTIFICATION OF THE HOUSEHOLDS AND REASONS FOR THEIR FORMATION IN RESOURCE POOR COMMUNITIES IN SOSHANGUVE, SOUTH AFRICA

IBEBUIKE, JULIA E., RN, RM, B.SC., M.ED

ADELAIDE TAMBO SCHOOL OF NURSING SCIENCE, TSHWANE UNIVERSITY OF TECHNOLOGY, PRETORIA, SOUTH AFRICA

VAN BELKUM, CORRIEN, HB SOC SC, M SOC SC, PHD

COLLEGE OF NURSING, KING SAUD BIN ABDULAZIS UNIVERSITY FOR HEALTH SCIENCES, RIYADH, SAUDI ARABIA

MAJA, TODD M.M., RN, CNM, PHD

ADELAIDE TAMBO SCHOOL OF NURSING SCIENCE, TSHWANE UNIVERSITY OF TECHNOLOGY, PRETORIA, SOUTH AFRICA

ABSTRACT

The Nelson Mandela Children's Fund in their 2001 report noted that South Africa has the fastest growing rate of people living with HIV/AIDS. This has led to an alarming increase in the number of children orphaned by AIDS and the attendant care of the orphaned children by their siblings. Our study aimed at identifying child headed households (CHHs) in the resource poor communities of Soshanguve Extension 12 and 13 in Pretoria, South Africa and to find out the reasons for the formation of these households. The study followed a qualitative, explorative design with a descriptive component for demographic data. It was conducted in the resource poor communities of Soshanguve Extension 12 and13 in the Gauteng province of South Africa. The research question: "How can children of child headed households be identified in the resource poor communities" guided the identification of these households and also aided to explore the reasons for the formation of these households. The participants for the study were purposively selected, and the criteria for inclusion in the study were children from 8-19 years of age and adult community members resident in the child headed households in Soshanguve Extension 12 and 13 as well as willingness to participate in the research. Data was collected using personal in-depth interviews and focus group interviews. From the data obtained, themes, categories and sub-categories were formed. The procedure for data analysis was adapted from the 8 steps Tesch's protocol. The study showed that CHHs in the resource poor communities of Soshanguve Extension 12 and 13 were identified through the help of the community leaders as well as a data base of these children obtained from a Non-Governmental Organization, Akanani Community Care Centre, located in Soshanguve Extension 12. And the reasons for the formation of these households include parental death, parental illness, parental abandonment, parental preparation, alcoholic parents, preservation of property, HIV and AIDS, and lack of care and maltreatment by

relatives. Based on our findings, we hope that the study serves important information in identifying CHHs in resource poor communities, especially in HIV/AIDS endemic areas and with the hope of caring for the households considering the serious socioeconomic problems faced by these households.

Key words: Child headed households, HIV, AIDS, identification, formation, resource poor communities, South Africa

Introduction

HIV and AIDS, armed conflicts and poverty-driven family disintegration are the three major causes for orphan hood and for the emergence of child headed households. However, HIV and AIDS remain the most subtle cause of the three, with the number of resultant orphans increasing at an alarming rate.

With a total of 22.5 million people infected as at the end of 2009, sub-Saharan Africa remains the region heavily affected by HIV and AIDS and with the highest numbers of AIDS-related deaths. Current figures (2009) confirm that 69% of all new HIV infections were concentrated in sub-Saharan Africa, 72% of all AIDS-related deaths happen in this region (Phillips, 2011:9; UNAIDS, 2010:20-21; UNICEF, 2009a:19). Sub-Saharan Africa is home to 80 per cent of all the children in the developing world who have lost a parent to HIV and AIDS (UNICEF, 2006:9), which remain the most common cause for orphan hood with the number of resultant orphans increasing at an alarming rate and leading to the formation of CHHs.

By 2009, more than 56 million children in sub-Saharan Africa had lost one or both parents due to a variety of reasons and the number of children without parental care is in the increase, mostly in Eastern and Southern Africa with approximately one quarter of the death of parents resulting from HIV/AIDS (Phillips, 2011:10-12; UNAIDS, 2010:48). The majority of these deaths result in children being deprived of one or both parents and give rise to child headed households. Other reasons resulting in loss of parental care are poverty, armed conflict and natural disasters. (Phillips, 2011:10-12; UNAIDS, 2010:20-21; UNICEF, 2009a:19). In Rwanda, conflict and poverty are the main causes of child headed households, as they result in displacement and serves to increase the number of orphans and estranged minors and decreases the number of potential carers (Maclellan, 2005:4; Phillips, 2011:146).

These conditions call for a look at South Africa were HIV positive people are 5.38 million from a population of 50,586,757 (Statistics South Africa, 2011:4). According to Meintjes *et al*. (2010:40-49), the Actuarial Society of South Africa in mid-2007 estimated that 4.1 million children had lost one or both parents in South Africa. Some children end up living together with their siblings while some have an adult in the household. All these led to the formation of households called child headed households.

Definition of Child headed household

There are several definitions of child headed households but a more practical definition as noted in a study by Tsegaye (2007:4-5) is a household which is headed by a person under 18 years old and who is: taking care of the household with other younger siblings, as they have lost both parents to HIV/AIDS or other causes; or providing the household income and taking care of the household with other younger siblings, whose parents or primary caregivers are chronically ill with HIV/AIDS or with other causes; or living alone and taking care of him/herself as no other siblings are present in the household and as either one of his

or her parents are deceased, or where the parents cannot be found or are unknown. This third category of children includes street children and child soldiers as noted in some studies.

However, Germann (2005:97) also defined a child headed household as a household where both parents or alternative adult caregiver are permanently absent and the responsibility for the day-to-day management of the entire household is presided by any person who is less than 20 years of age.

The children of child headed households are not necessarily orphans since their ailing parents may live with them but needs care. There could be other adults staying in a CHH. These adults may include old grandparents, disabled uncles/aunts, or even some other adult relatives who are not responsible for the household. These households with dependant adults are called *accompanied child headed households*, as opposed to *unaccompanied child headed households* where no adults more than 18 years-old are found (Foster *et al*., 1997:155-168; Tsegaye, 2007:5). The differentiation is of importance as the presence of parents can be a strong safeguard against external harms. Even when sick, they can continue to provide protection and guidance for the children as no other adults would attempt to harm the children when parents or other adults remain under the roof. When the adults die, children can become victims of possible abuse and exploitation and are deprived of any protection. All these happen within their childhood period.

According to Skinner *et al*. (2004:15), the extension of the childhood period may be due to different situations, specifically the period of dependency. Skinner *et al*. (2004:15) is of the opinion that in African communities the person may remain a child beyond the legally defined time frame. Subjective sources from the media suggest in a number of community settings in South Africa that even youngsters older than 18 years are regarded as children. Consequently, any endeavour to define child headed household incorporates both the legal and contextual definition. For the purpose of this study, children above 18 years but not exceeding 19 years will be included as a "child". The child in this context is a child who has been identified living in a child headed household.

Research methods and design

A qualitative and descriptive design was used to provide information on the demographic profile of the participants from child headed households, the methods of identification of children of child headed households as well as the reasons for the formation of these households.

Population and sample selection

The target population for this study were children in child headed households, as well as adult persons residing in Soshanguve Extension 12 and 13. A non-probability, purposive sampling design was used to select participants for the study (Pilot & Beck, 2008:343). This is used to select participants that are aware of the phenomenon and who are able to explain the phenomenon (Anyanegbunam, 2004:20). Purposive sampling implies that with good judgement and acceptable approach, the researcher can credibly and intentionally include the sample participants who are judged to be characteristics of the population being investigated (Isangedighi *et al.*, 2004:9).

The criteria for inclusion in the study were:

- Children from 8-19 years of age resident in child headed households in Soshanguve Extension 12 and 13.

- Adult community members resident in Soshanguve Extension 12 and 13.
- Willingness to participate in the research.

A project team was formed to guide the conduct of this research and consisted of an advisory committee (consisted of some selected adult members of the communities as well as some community leaders), a registered postgraduate South African community health nurse (who doubled as a translator and field worker) working in the mobile clinic in Soshanguve, community leaders and the researcher. This was done to gain entrance into the community to conduct the research. Community involvement is a critical element for successful problem solving within that community (Anderson & McFarlane, 2008:94). Anderson and McFarlane (2008:94) further suggested that the essential elements to community participation includes defining the community, shared awareness by members of the community and mechanisms to make the community to recognize her needs and develop a culture of participation. Burns and Grove (2009: 320) states that the researcher must include the advisory committee in discussions and create awareness on what is demanded from them. The building of trust among all involved partners and participants is gained in order to collaborate on community efforts and help the children in child headed households identify their needs. Anderson and McFarlane (2008:94) noted that community participation is a process involving people from specific geographical locality who share common values in identifying their needs.

The sample size for the participants from the child headed households was determined by the saturation of data. That is when no new information or relevant data emerged (Leedy & Ormrod, 2001:219). The Akanani Community Care Centre has a data base of all child headed households in the resource poor communities of Soshanguve Extension 12 and 13, and there were seventeen (17) households in number. The community leaders purposively selected one child from each household who satisfied the criteria for inclusion. This was agreed by the project team to ensure privacy for the participants and to also assure them of confidentiality. Therefore a total of 17 participants from child headed households in the resource poor communities were brought by the community leaders for in-depth interviews. Data were saturated after fifteen (n = 15) interviews. Focus group discussions were also conducted and four distinct focus groups emerged as well after saturation of data. The community leaders and advisory committee members within the project team purposively selected the focus group participants, who consisted of adult members of the communities and two children (per group) from among those purposively selected for in-depth interviews. The sample size for a focus group tends to be inadequate if the participants are few in number, and so a suitable number for each focus group should include 6 to 10 participants (Burns & Grove, 2009:513).

Data gathering

Qualitative data gathering inquiries were done through unstructured in-depth interviews, focus groups, self-report and field notes. In-depth interviews were conducted for the children in child headed households to explore their knowledge about how such children can be identified in the communities. Focus group interviews were also held and involved

brainstorming, and centered on discussions about knowledge of the resource poor communities about child headed households (Yoo *et al*., 2009:264). The interview sessions were written down in a book to aid free listing of identified issues and at the same time the interviews were recorded with a voice recorder. The free listing related to observed and identified issues on identification of children of child headed households. Data was collected through unstructured in-depth personal interviews from the children in CHHs and focus group discussions made up of adult participants and two children per group from the child headed households. The interviews took place in a private room in a mobile clinic in Soshanguve Extension 12 on different occasions and ensured privacy and avoidance of public exposure.

Data analysis

Quantitative data on the demographic profile of the children from child headed households was analysed for age group, gender and type of household for the participants from the child headed households. The products of the qualitative data-gathering processes (field notes, self-report, transcribed audio-recordings of interviews and discussions) were thematically analysed to reveal the participants' (from child headed households) knowledge about existence of child headed households, the reasons for the formation of child headed households and the resource poor communities' knowledge about child headed households.

Measures to ensure trustworthiness

Trustworthiness or the merits of qualitative enquiry is the process of demonstrating credibility, transferability, dependability and authenticity. It refers to the degree of confidence qualitative researchers have in their data using the above criteria and as outlined below (Table 1) (Polit & Beck, 2008:539-540, 751).

TABLE 1: Measures to ensure trustworthiness

Trustworthiness Criteria	***Assessment Criteria***	***Implementation***
Credibility "Truth value"	Prolonged engagement	Known to community Trusting relationship Interviewed in a private room within a mobile clinic (privacy) Goes back to clarify/ask more questions
	Triangulation	Applied through various data gathering instruments
	Peer debriefing	Through discussions with similar status colleague Pre-liminary research findings presented to experts and peers (colloquium)
	Member checking	During interviews: statements were summarized and verified to be the truth
Transferability • Applicability	Selection of sources/sampling	Children in CHHs from ages 8-19 years and adult community

		members from Soshanguve Extension 12 and 13 were purposively sampled for this research
	Saturation of data	Interviews conducted until data saturated
	Thick/dense description	Thorough descriptions of the population, sampling and results
Dependability • Consistency	Dependability audit	In-depth interviews
	Traceable variability ascribed to identifiable sources	Interviews were numbered and transcribed before allocation of themes
	Stepwise replication	Processes followed were exactly the same with all interviews
	Thick and dense description	Thorough descriptions of the research methodology of the research process
Confirmability • Neutrality	Confirmability audit	The findings of the research - are based on data gathered from the interviews - are not based on the researchers own opinions - does not reflect motive and perspectives Researcher implemented audit on trustworthiness of the research approach
	Triangulation	Applied through various data gathering instruments
	Reflexivity	Only the data gathered were described (reflected upon)
• Authenticity	Heightened sensitivity to the issues	Referring to the respondents own words heightened sensitivity

Ethical considerations

Ethics is the branch of philosophy that deals with morality (Burns & Grove, 2009:61). Permission to conduct the study was sought and obtained from the Ethics Committee of Tshwane University of Technology, the Departmental Research and Innovation Committee (DRIC), the Faculty Higher Degrees Committee, and the University-based Nursing Education South Africa (UNEDSA) NCoP Programme Manager who is the head of the mobile clinic. Informed assent was obtained from each participant below 18 years of age while informed consent was obtained from adult participants who formed the focus groups and advisory committee. Confidential agreement forms were completed and signed by all participants and project team members. The transcribed interviews were numbered to ensure anonymity and confidentiality. No harm was intended and when emotional discomfort was experienced, time was allowed to give support and counselling. The

interviews were conducted in a private room in the mobile clinic to ensure privacy and utmost respect of participants was maintained. Participation in the research was voluntary and therefore, participants were at liberty to decline or withdraw their participation at any time if they so desired.

Findings of the study

The sample size was 17 participants (n=17) with each child from 17 different child headed households in the resource poor communities, with saturation reached after fifteen (15) participants. The researcher then conducted further two interviews with no new information.

Demographic profile of participants from child headed households

The general characteristics of the 17 participants are presented using frequency table.

The distribution of gender, age group and type of child headed households among the participants is shown in Table 2.

TABLE 2: Gender, age group and type of CHHs

Criterion	Frequency	Percentage
Gender		
Male	9	52.9%
Female	8	47.1%
Total	17	100%
Age group		
8 - 9 years	4	23.5 %
10 -11 years	3	17.6 %
12 -13 years	2	11.8 %
14 - 15 years	2	11.8 %
16 – 17 years	3	17.6 %
18 -19 years	3	17.6 %
Total	17	100.0 %
Type of CHHs		
Unaccompanied	10	58.8%
Accompanied	7	41.2%
Total	17	100%

From Table 2, the male participants were nine (52.9%), females eight (47.1%), the youngest participants were between 8–9 years while the eldest were 18-19 years in the study. The participants' distribution with respect to the type of CHHs showed that 10 (58.8%) were from unaccompanied CHHs while 7 (41.2%) were from accompanied CHHs.

Findings from in-depth interviews of participants from child headed households

The following findings were obtained from the participants during in-depth interviews and include the main themes (knowledge about existence of CHHs, reasons for the formation of CHHs), categories and sub-categories that emerged from the data as shown in Table 3.

TABLE 3: Themes, categories and sub-categories from in-depth interviews of participants from CHHs

Themes	**Categories**	**Sub-categories**
Knowledge about existence of CHHs	Awareness of CHHs	• Acquainted with CHHs • Unaccompanied CHHs • Accompanied CHHs
	Identification of children of CHHs	• Ease of identification of children of CHHs • Method of identification of children of CHHs
Reasons for the formation of CHHs	Parental death	• Cause of parental death
	Death of a single parent and property preservation	• Single parentage by mother and mother's last wishes
	Death of a parent and abandonment by the surviving parent	• Death of mother and abandonment by father
	Parental preparation	• Request for a relative

Theme 1: Knowledge about existence of child headed households

A summary of the in-depth interviews exploring the participants' knowledge about the existence of child headed households are presented with verbatim quotes from the participants as shown in Table 4.

TABLE 4: Summary of knowledge about existence of child headed households

Theme	**Categories**	**Sub-categories**	**Verbatim quotes**
Knowledge about existence of CHHs	Awareness of CHHs	Acquainted with CHHs	Yes l know children like me living with their siblings or with their grandmother. Most of them are my friends and we use to move together in school, but now l stay at

			home. Most of the children that play around during school hours in the community live in child headed households.
		Unaccompanied CHHs	My parents died when l was 13 years old and thereafter l have been staying with my sibling all alone in our late mother's house with no one else to help us.
		Accompanied CHHs	My aged grandmother resides with us. My parents are dead. My grandmother began to stay with us when my late mother became very sick.
	Identification of children of CHHs	Ease of identification of children of CHHs	It is easy to identify these households. I think you can ask anyone on the street within Soshanguve Extension 12 and 13.
			It is not easy…

			because the community is bad. You must not expose yourself to evil and talking (gossips).
		Method of identification of children of CHHs	Most of the children that play around during school hours in the community live in child headed households. If you come around during school hours you will meet most of them. If you don't have the time, inform the community leaders to assist you or those living around.

Theme 2: Reasons for the formation of child headed households

A summary of the in-depth interviews exploring the participants' reasons for the formation of child headed households are presented with verbatim quotes from the participants as shown in Table 5.

TABLE 5: Summary of reasons for the formation of child headed households

Theme	**Categories**	**Sub-categories**	**Verbatim quotes**
Reasons for the formation of child headed households	Parental death	Cause of parental death	We started staying alone when our parents died. My parents died of

			alcohol and AIDS. My father died in 2005 and my mother died in 2006. I was only 9 years old when my mother died.
	Death of a single parent and property preservation	Single parentage by mother and mother's last wishes	My mother did not show me my father, but now she is dead. I and my elder sister stay alone. We stay in an RDP (Reconstruction and Development Programme) house in Soshanguve Extension 12. The house belongs to my late mother. My late mother informed us on her dying bed never to forsake each other. We should take care of her property, rent out a

			room and use it for feeding.
	Death of a parent and abandonment by the surviving parent	Death of mother and abandonment by father	Immediately after my mother's death, my father left us to where he had a new job in Pietersburg. There he lives with another woman and he's less interested in what goes on in this house. Initially he comes around occasionally but now he does not come around again and things have become very difficult for us.
	Parental preparation	Request for a relative	My mother and father became very sick. My uncle had to pack in to stay and fulfil my parents' desire for a relative to live and take care of

		us. It was as if they knew what was going to happen and so they spoke to my uncle and told me they had Tuberculosis. My uncle is 19 years old, I am 17 years old and my junior brother is 8 years old and we are just three of us staying together.

Findings from focus group discussions

There were 4 focus groups consisting of adult community members and 2 children from a child headed household per group. The four separate groups were focus group one which consisted of a mixed gender (n=10), focus group two which was made up of female gender (n=7), focus group three which was again of mixed gender (n=8) and focus group four which was made up of male gender (n=7). As noted by Burns and Grove (2009:513), focus group is a design for obtaining the participant's perceptions in a focused area in a setting that is permissive and non-threatening; hence its utilization to gather information on the resource poor communities' knowledge about child headed households. Initial categories and sub-categories emerged during the data analysis process and these were clustered together to form the main theme. The theme generated from the focus group data relating to the resource poor communities' knowledge about child headed households is presented in Table 6.

TABLE 6: Theme, categories and sub-categories from focus group discussions

Themes	**Categories**	**Sub-categories**
Resource poor communities' knowledge about child headed households	Awareness of existence of child headed households	• Acquainted with CHHs • Accompanied CHHs • Unaccompanied CHHs
	Identification of children of CHHs	• Ease of identification of children of CHHs • Methods of identification of

		children of CHHs
	Reasons for the formation of CHHs	• Death of parents • Alcoholic parents • HIV and AIDS • Parental illness • Parental abandonment • Lack of care and maltreatment by relatives

Theme: Resource poor communities' knowledge about child headed households

A summary of the focus group discussions exploring the resource poor communities' knowledge about child headed households are presented with verbatim quotes from the participants as shown in Table 7.

TABLE 7: Summary of resource poor communities' knowledge about child headed households

Theme	**Categories**	**Sub-categories**	**Verbatim quotes**
Resource poor communities' knowledge about child headed households	Awareness of existence of child headed households	Acquainted with CHHs	Yes, we have these children that are living alone in this community, because they have no parents. These households are increasing every year because our people keep conducting funerals every month and the children are left alone in shacks.
		Accompanied child headed household	Most of the children live in these shacks with their old grandmother or old relatives who even find it difficult to provide for the care of the children. The children still move out to seek for assistance and to eat with other children in the community.
		Unaccompanied Child headed households	Yes, yes, there are so many of these children living alone with their siblings and with no adult in their household to care for them.
			Yes, there are households where the children live alone after the death of their parents because they

			have no grandparents, so they don't have a choice.
	Identification of children of child headed households	Ease of identification of children of child headed households	Sometimes it is difficult because the children are aware of what led to the death of their parents, so they hide their identity and will not tell you that they are orphans, so as to protect themselves because of gossiping by community members on what killed their parents.
			Here in Extension 12 it is easy to identify these households through the NGO located here.
		Methods of identification of children of child headed households	We have an NGO here in Extension 12 controlled by the community leaders who know everything about these children.
			Ask a community leader in Extension 13. These children in child headed households cannot easily be identified except you go through the community leaders.
	Reasons for formation of child headed households	Death of parents	These households are formed due to death of their parents.
		Alcoholic parents	These child headed households are formed because of alcohol abuse by some parents who are busy drinking the whole night; they do not care about their children's welfare. These children are dirty and hungry and, for some of these children their parents are alive but their parents are nearly 24 hours drunk from alcohol. This results in these children packing out to

			live alone with their siblings.
		HIV and AIDS	We agree as Extension 13 that the main cause of child headed households is HIV and AIDS because it is a very dangerous disease.
		Parental illness	The parents become very sick and cannot do anything, the children cook and take care of their sibling.
		Parental abandonment	The children kept struggling alone, without food, no money for school transport and they stay for weeks without seeing their father after their mother's death. The father moves out and finds a job far from home where he remarries and forgets the children.
		Lack of care and maltreatment by relatives	If these orphaned children do not receive government grant the relative will not want to assist them because they don't have any income to maintain them. The relatives that assist the children with no income end up using them for household jobs. Then you will see the children when they reach teenage age running away to live with their siblings because of hunger and maltreatment from some relatives.

Discussion of findings

A child has been defined as a person within the age range 0-18 years (UNICEF, 1989:1; Sloth-Nielsen, 2004:4), though the childhood period may be extended in relation to the period of dependency (Skinner *et al*., 2004:15). Corresponding to this, Tsegaye (2007:3) defined a child headed household as a household headed by a person under 18 years old

while Germann (2005:97) defined it as household where the person responsible for the day-to-day management of the entire household is less than 20 years of age. The participants in this study were all within 19 years of age, Black Africans living in child headed households and majority were of the Sepedi cultural group (47%). In a study by Korevaar (2009:73) in Pretoria, the participants differed on the age constitution of CHHs. While one group considered CHHs to be a household headed by a child under 18 years of age, another group considered CHHs to be where the eldest child is 21 years of age or younger. Also in their study, some participants discussed households where the eldest child was over 21 years of age and still considered these to be child headed households.

It should be noted that the Children's Bill of Rights makes provision for the legal recognition of child headed households as a type of family unit in South Africa (Sloth-Nielsen, 2004:25; Maqoko & Dreyer, 2007:724; Department of Social Development, 2010:9). Hence this study was performed to study this group of family unit, their identification within the resource poor communities and the reasons for the formation of these households.

Identification of children of child headed households

The identification of children of child headed households (CHHs) was inferred from the theme on knowledge about existence of child headed households.

Knowledge about existence of child headed households

Category 1: *Awareness of child headed households (CHHs)*

Sub-category 1: *Acquainted with child headed households*

The study showed that all the participants were acquainted with the term "child headed household". Maqoko and Dreyer (2007:718, 724) noted that child headed households are not new in the South African society, although not much researched into to gradually expand the knowledge. And the subject of child headed households has been suggested as a problem that is more extensive than some studies sense it to be (Phillips, 2011:156). The knowledge of existence by both the affected and afflicted may be the reason why South Africa has provided legal recognition for child headed households and included it as a type of family.

Sub-categories 2 and 3: *Unaccompanied and accompanied child headed households*

The participants were ignorant of the term unaccompanied CHHs but when probed further with description for what constitutes unaccompanied CHHs (CHHs without accompanied adults in the household), 10 of the participants expressed belonging to unaccompanied CHHs. Seven of the participants expressed belonging to accompanied CHHs after the participants were educated on the composition of accompanied CHHs. Hence the study findings showed that there were more unaccompanied (10) child headed households than accompanied (7) child headed households in the resource poor communities. In a study on child headed households in Ethiopia, there were 66 unaccompanied and 42 accompanied child headed households in five different towns and their rural surroundings (Tsegaye,

2008:25). These may seem to suggest that unaccompanied CHHs tend to be more than accompanied CHHs, and may indicate that the trend favours siblings preferring to stay together even without adult carers. And this may agree with reports that children without adult caregivers prefer to stay in their homes as a unit rather than being scattered among relatives or foster care homes (Chilangwa, 2004:7; Tsegaye, 2007:6). However, a study by Ayieko (1997:11) in Kenya revealed that 5.2% of the studied families were headed by children with no presence of an adult. This very low trend in Kenya may be due to the fact that most Kenyans live within communities of extended families and kin in rural areas, thereby aiding in the provision of support for orphaned children within their own villages and among their extended families (Ayieko, 1997:1).

Category 2: *Identification of children of child headed households*

The findings from the in-depth interviews of the 17 participants utilized for the study revealed that their households consisted of 13 double orphaned CHHs and 4 single orphaned CHHs. Among these participants, the highest number of children in a household was 4 children while the lowest number was one child who resided in an accompanied child headed household. Also the youngest age of children in the households of the participants was 1 year while the oldest age was 19 years. Thirteen households were headed by females while 4 households were headed by males. The findings correspond with other reports which indicate that CHHs are predominantly headed by female children (SACBC, 2009:1; Tsegaye, 2008:25) though Luzze (2002:31) had more males (80%) as head of CHHs than females in his study in Uganda. Tsegaye (2008:25) in Ethiopia noted more females (59%) as heads of CHHs than males (41%) and reports that the presence of an adolescent female in a household that has no adult carer tends to trigger the formation of child headed household. This may be a reason for the high number of females as heads of CHHs among participants in this study in Soshaunguve. Luzze (2002:31) attributes his contrasting findings in Uganda to be due to the fact that cultural factors like attaching inheritance and wealth to male children probably makes it much easier for the formation of CHHs headed by a male, than one headed by a female. Also Luzze (2002:32-36) in his study in Uganda reported 4 to 6 children in 60% of child headed households; 1 to 3 children in 29% of the households and over 7 children in 11% of CHHs with the highest households consisting of 12 children (Luzze, 2002:33). This indicates a trend toward higher number of siblings per household in Luzze's study when compared to this study in Soshanguve. Tsegaye's (2008:25) study in Ethiopia which noted that a third of unaccompanied child headed households had 3 siblings, nearly a quarter had 1 child living alone, 11% had 5 siblings and 5% had 6 siblings, showed a trend toward lower number of siblings per household.

1 and 2: *Ease and methods of identification of children of child headed households*

Twelve of the participants said that it is difficult to identify children of CHHs due to the fear of exposing their orphan hood. This implies that the children from CHHs tend to hide their orphan hood from the community probably to avoid discrimination. However, the rest of the participants had different views with 2 of the participants saying that it was easy to identify the children, 2 others said they do not know how the children can be identified while one was non-committal The 2 participants who expressed that it was easy to identify these children stated that this can easily be realized by asking for child headed households

from community members. This may imply that the communities are aware of these households among them.

Three methods stand out from the participants' responses regarding how to identify children of CHHs and these include:

- asking the community leaders,
- asking the members of the communities and
- watching out for street children during school hours.

The community leaders through the Akanani Community Care Centre kept a data base of all child headed households in the resource poor communities. The other 2 methods generally relates to identification of the children of CHHs by observation. This is similar to the findings of other studies (UNISA, 2008:121) which also revealed, among other methods, that children of CHHs were identified by the observation of neighbours (who by virtue of proximity discerned that the parents were absent), teachers (who noticed the children were unkempt and often late to school) and members of the communities (who noticed the children's street loitering).

Reasons for the formation of child headed households

The reasons for the formation of child headed households in this study were reported as

- parental death by 12 participants,
- death of a single parent and the desire to preserve the family property (1 participant),
- death of a parent and abandonment by the surviving parent (3 participants) and
- parental request for a relative to stay with the children in the household (1 participant).

Category 1: *Parental death*

Although parental death was responsible for the occurrence of the 13 double orphaned participants recorded in this study, one of the double orphaned participants did not consider parental death as a sole reason for the formation of their CHHs. Rather and probably in addition to parental death; this household noted the reason for the formation of CHHs as parental preparation. The formation of CHHs after parental death may reflect the report by Maqoko and Dreyer (2007:724) who noted that child headed households were formed when brothers and sisters vowed to stay together after the demise of their parents in their homes.

Sub-category: *Cause of parental death*

Only five of the double orphaned participants knew the exact cause of their parent's death and related their parents' death to HIV/AIDS; though some of them also noted a probable additional influence of alcoholism while a child noted kidney disease as the cause of father's death. The other 7 double orphaned participants who had no idea about the cause of their parents' death may have been denied this knowledge to avoid the stigma associated with the possible knowledge of the cause of their parents' death especially if due to HIV/AIDS. Korevaar (2009:124) when assessing attitude towards bereavement and death noted that only one participant claimed that children were informed honestly of parental death. Rather children were lied to that the parents will be coming back. Also Nkomo (2006:97) in South Africa noted that the public images and views of HIV/AIDS

can result in hopelessness and despair as well as fears of being stigmatised among participants. However, Mogotlane *et al.* (2010:29) noted that although in many cases, the parents would have died without revealing their status; people in the community generally had their own impressions about the possible diagnosis. Tsegaye (2008:25) in Ethiopia noted that CHHs were formed following the death of parents or caregivers from HIV/AIDS, while some were formed after parental separation or for other reasons. This is also supported by the findings of Mogotlane *et al.* (2010:29) which showed the reasons for the formation of CHHs as death of one (40.3%) or both (43.3%) parents mainly as a result of HIV and AIDS.

Category 2: *Death of a single parent and property preservation*
Another reason for the formation of CHHs in this study was the death of a single parent who expressed a dying wish for her children to stay together and preserve the family house. Death of a single parent independently may be a reason for the formation of CHHs, just as preservation of family property by the orphaned children may also be an independent reason for CHHs formation. Mogotlane *et al.* (2010:29) noted that death of one parent constituted 40.3% of the reasons for the formation of CHHs.

Sub-category: *Single parentage by mother and mother's last wishes*
In this study in Soshanguve, a single maternal mother's dying wishes mandated the children to stay together and preserve the family home. The children were also advised to rent a room in the building for added income for their subsistence. This corresponds with a report by Tsegaye (2008:25) that children may chose not to be integrated into relatives' households in order to keep the promises made to dying parents or due to fear of abuse and their desire to stay together as one family. Tsegaye (2008:25) also noted that CHHs were formed because some children wanted to keep inherited property, land, housing or small amounts of money from their parents rather than move in with relatives.

Category 3: *Death of a parent and abandonment by the surviving parent*
The study also revealed that one of the reasons for the formation of CHHs was parental abandonment after the death of a single parent (3 participants). This involved mainly the death of maternal parents whose demise and the subsequent abandonment of the children by the surviving paternal parent led to the formation of CHHs. The fathers abandon their children and avoid any physical or financial involvement. The resultant effects are parentless children as these fathers never attempt to come back for the children. The reasons given for the paternal abandonment included search for job far away from home or relocation to another town or city after marriage to new partners. Nkomo (2006:100) noted that abandonment and desertion by relatives played a part in the formation of child headed households. Urban migration by parents and their search for job have been noted as contributory factors to the formation of CHHs as children are left in the care of family members, usually grandmothers (Korevaar, 2009:12). A high rate of father absenteeism where many fathers do not live with the mother of their child due to high migration has also been considered contributory to the emergence of CHHs (Korevaar, 2009:12). This may explain the scenario in one of the participants in our study in Soshanguve, a 17-year old orphan raised by a single mother who never told him who his father was. In Malawi some cultural practices involve the father leaving the house to remarry without taking care of the children when their mother dies, resulting in the children often times living alone

(UNICEF, 2008:1). However, reports have also indicated that a few of these children in child headed households were abandoned by their parents (Germann, 2005:39).

Category 4: *Parental preparation*
One of the child headed household in this study was formed due to prior preparation by the parents of the children who requested a relative to come in and stay in their home during the terminal stage of the parents' illness. This household was peculiar because the relative in question was also a child (19 years) though a male child and probably the arrangement aimed at providing male support to a household that would have been headed by a female child (17 years). This male relative subsequently assumed headship of this household after the death of the children's parents. A report noted that what seemed to be expected from most parents who are aware of their terminal illness are attempts to make alternative living arrangements for their children before their death in order to prevent the formation of CHHs, the neglect of this alternative living arrangement is considered a factor in the emergence of CHHs (Ayieko, 1997:1). However, the case of this participant in our study is where a living arrangement by the terminally ill parents seemed to have encouraged the emergence of CHHs.

Resource poor communities' knowledge about child headed households
In further exploring this study on identification of CHHs in resource poor communities and the reasons for their formation, the communities' knowledge about child headed households (through focus group discussions) gave insight about these households from the communities' perspective.

Category 1*: Awareness of existence of child headed households*
The participants from all the 4 focus groups were aware of the existence of CHHs in Soshanguve Extension 12 and 13. The participants were also aware that some children live alone with their siblings without adult supervision in their households, while other children live under the supervision of adults such as grandmothers or aunties whose role seemed to be an adult cover for the children while the children themselves managed the households' affairs. They also noted that the number of child headed households is on the increase in the resource poor communities primarily due to the devastation of HIV and AIDS. This corresponds with the observation of an unprecedented increase in the occurrence of child headed households from the early 1990s (Phillips, 2011:10).

2 and 3: *Acquainted with child headed households namely accompanied and unaccompanied CHHs*
The study showed that the focus group participants were acquainted with the two subtypes of child headed households which are accompanied and unaccompanied CHHs. The study also revealed that adult members in accompanied CHHs were mostly the children's aged grandmothers. In some cases the children's aunty or other extended family relative was the adult occupant in the household. However, there are reports of an increasing proportion of orphans not only being under the care of the elderly but also under care of the very young (Foster *et al.*, 1997:155), as was observed in one of our participant in this study in Soshanguve whose household was headed by an uncle who being 19 years of age was also considered to be a child by the researcher and, therefore the household was still considered as unaccompanied CHHs. The study also revealed that an accompanied CHH were considered a better option because of the presence of an adult. Reports note that

accompanied CHHs seem to be favoured because the support of a caring adult environment may help the children to overcome the anticipated delayed developmental changes consequent to the death of their parents, and thereby prevent any negative long-term impact (Germann, 2005:242). Ayieko (1997:1) in Kenya also noted that children undergo better development socially, mentally and emotionally when they are raised in familiar surroundings with extended families.

Category 2: *Identification of children of child headed households*
Most of the participants in the focus group discussions considered the identification of children of child headed households as difficult. Some of the reasons why the participants considered the identification of these children as difficult include the children's deliberate effort to hide from the communities due to the communities' knowledge of what may have led to their parents' demise.

1 and 2: *Ease and methods of identification of children of child headed households*
The participants were divided in their responses regarding the ease of identification of children of CHHs with most of the participants indicating that it was difficult to identify the children, while others said it was easy. The most common underlying reason for the difficulty in identification of these children as noted by participants relates to the children avoiding exposure of their identity as orphans especially where their parents' death was due to HIV/AIDS. This aimed at preventing being gossiped by community members and the attendant psychological effect of such gossip on the children. The easy approach to identify the children as noted by the participants is to ask the community leaders or to go through the Akanani Community Care Centre (a community based NGO) in Extension 12. These also constituted the two listed methods by the focus group participants on how to identify the children within the resource poor communities. Reports in the literature also noted that the identification of children in CHHs is difficult due to lack of co-operation on the side of the community (Roalkvam, 2005:212). This corresponds with the report by the Nelson Mandela Children's Fund (2001:3) that the key players directly involved in service provision for identification of child headed households were NGOs, Church organizations, Health workers and Community. Other methods that have been used to identify these children include through publicity campaigns involving television, radio and community facilities aimed at helping to identify the children wherever they may be found (DA's Policy, 2012:1). The community leaders tend to be central figures in any business that involves the community. However, Francis-Chizororo (2007:19) in Zimbabwe reported that adult interviewees tended to identify orphans (not specifically CHHs) as dirty children, school dropouts, always borrowing, working to survive, and having no food.

Category 3: *Reasons for formation of child headed households*
The study revealed various reasons from the communities' perspective for the formation of child headed households in the resource poor communities of Soshanguve Extension 12 and 13. These include:

- death of parents,
- alcoholic parents,
- HIV and AIDS,
- parental illness,
- parental abandonment and
- lack of care and maltreatment by relatives.

Death of parents is the primary underlying reason for the formation of CHHs as noted by reports in the literature (Alliance, 2006:2; Tsegaye, 2007:4; UNAIDS, 2008:12, 20; Mogotlane *et al*., 2010:24-32).

The focus group discussions in this study revealed that some child headed households were formed because the children opted to live together away from their parents who were considered unhelpful and uncaring due to the effects of alcoholism in the parents. Though these children's parents are alive, they preferred to move out of their parents' home to live alone because they felt they will be better off that way than living with their persistently drunk parents who cared less about them. Reports by WHO (2012:1) indicate that alcohol makes parents to always argue at home, neglect their family obligations, and manifest role change and conflict, co-dependence, quarrel, domestic accident, physical violence, long absence from home, frequent marital separation and divorce. Family members experience guilt, shame, anger and isolation due to the presences of an alcohol addict. The children from CHHs are often exposed to moderate to severe forms of harassment, conflict and tense atmosphere, and the alcohol addict is always abusing family members (WHO 2012:1). These may also reflect the situation some of the children in this study in Soshanguve found themselves in and which resulted in their forming unaccompanied CHHs with their siblings.

The study also revealed that the focus group participants considered the devastation of HIV and AIDS as the main cause of CHHs. This probably implies HIV and AIDS related death of the children's parents. This is supported by reports in the literature indicating HIV/AIDS as a major factor leading to the establishment of CHHs as well as the increase in the number of these households in sub-Saharan Africa, with a progression from an initial increase in the number of single orphans to a later increase in the number of double orphans (Phillips 2011:151-152). Also Tsegaye (2008:25) in Ethiopia noted that most of the contacted child headed households in her study were established following the death of their parents or caregivers from HIV/ AIDS.

The study also revealed that parental illness was one of the reasons for the formation of CHHs. This probably supports the findings from in-depth interviews of the children in this study where the participants from the CHHs noted illness such as kidney disease as a cause of parental death. These are illnesses that has a natural history of chronicity and therefore affects the productivity of the afflicted making them dependent on others for care. This corresponds with a study in Zimbabwe by German (2005:238) who noted that prolonged illness of at least one parent was observed in all CHHs while 57% of the CHHs experienced it with both parents. The parents become progressively less likely to supervise or even discipline their children in that state of health. German (2005:239) also noted that in majority of cases (82%), the heads of CHHs had been primary caregivers during the parental illness.

The study findings also revealed that some CHHs were formed because the children were abandoned by their parents. Some of the scenarios involved the death of the children's mother and the subsequent departure of their father in search of job in another environment, remarriage of their father at the new environment and never bothering about the children from his late wife. Another scenario is where the father remarries after the death of the children's mother and decides to forget the children from his late wife and to go on with life in a new home with his new wife. Other scenarios revealed from the study include abandonment of the children by a single parent; separation of the parents and subsequent abandonment of the children; and parents living away from the children while

keeping the children under the care of their aged grandmother but subsequently abandoning the children who have to start fending for themselves. This is similar to reports in the literature which noted that when many parents migrate to urban areas to find jobs, children were left under the care of family members, typically the grandmother, who plays a vital role in raising the children (Korevaar, 2009:12). Also it has been noted that migration has resulted in a high rate of father absenteeism and also many fathers do not live with the mother of their child (Korevaar, 2009:12). This probably explains the situation of the participant in our study in Soshanguve who never knew his father, though his comment was that his late mother never told him who his father was.

Lack of care and maltreatment by relatives were also found as reasons for the formation of CHHs in this study. The study found that this is usually evident among children with no government grant and therefore will need full support from their relatives but who refuse caring for the children because they claim not to have income to maintain the children. The implication of these may be that considerations are made by some relatives to care for some of the orphaned children, but this appears to be a favourable situation for children on government grant, as most of these relatives are probably jobless and do not have the personal funds to care for the children. The relatives that have no income but accept to assist the children end up using them for domestic household jobs. The children also faced hunger and maltreatment in these homes and therefore run away to live with their siblings especially in the teens. This corresponds to the report by Francis-Chizororo (2007:29) in Zimbabwe which noted that orphans taken in by relatives had limited time to play and socialize, leading them to run away. It was noted that ill-treatment makes orphans to want to find ways to create their own social worlds over where they feel they may have more control for themselves (Francis-Chizororo, 2007:29). Our study findings are similar to that of Dijk and Francien (2009:923) in Port Elizabeth, South Africa, where a 16 year old female child moved in with a family that was supporting her but was treated differently from the biological children of the family and despite the family obtaining foster care grant on her behalf, the money was never spent on her. This resulted in frequent fights and she had to return to her own household and never received support from that particular family anymore. Our study findings are also supported by reports in the literature which noted that instead of being a helpful resource, the extended family may rather contribute to a child's vulnerability by treating children that they take in worse than other children in the home such as making them perform more domestic responsibilities, or to work for an income (Bronwyn, 2007:7).

Conclusion

The study has shown that child headed households remain societal issues in our environment and supports the observation that the phenomenon of CHHs is a problem in our environment.

The identification of these children in the resource poor communities through a database in an existing NGO in the communities showed that the existence of these children is known in the communities and they can therefore be easily reached for purposes of being helped. The resource poor communities' knowledge about CHHs further confirmed an awareness of their existence, and therefore a community-based programme to support these children may be well supported by the resource poor communities.

ACKNOWLEDGEMENTS

The authors would like to acknowledge the Tshwane University of Technology and as well thank the Adelaide Tambo School of Nursing Science for presenting the learning opportunity and support for academic development. We acknowledge the Akanani Community Care Centre and the Community Leaders of the resource poor communities of Soshanguve Extension 12 and 13 for permitting us to conduct the study in their communities. To the study participants from child headed households and the focus group participants, this study would not have been successful without their participation.

REFERENCES

ALLIANCE. 2006. *A situational analysis of child headed household and in community foster care in Tamil Nadu and Andhra Pradesh State, India*. International HIV Alliance. [Online]. Available from: http://www.eldis.org/assets/Docs/24634.html [Accessed 15/10/12].

ANDERSON, E.T. & MCFARLANE, J. 2008. *Community as partner: Theory and practice in Nursing*. 5th ed. Lippincott William & Wilkins.

ANYANEGBUNAM, I.U. 2004. *Research methods for student nurses and midwives.* Nnamani publisher*:* Onitsha, Nigeria.

AYIEKO, M.A. 1997. *From single parents to child headed households:* The case of children orphaned by Aids in Kisumu and Siaya Districts. HIV and Development Program, Study Paper No.7 [Online]. Available from: http://www.undo.org/hiv/publication/study/english/sp7e.htm [Accessed: 09/01/2011].

BRONWYN, M. 2007. *Parentification in Child Headed Households within the context of HIV AND AIDS*, M.Sc. dissertation, University of Witwatersrand: Johannesburg.

BURNS, N. & GROVE, S.K. 2009. *The Practice of Nursing Research: Appraisal, Synthesis, and Generation of Evidence.* 6th ed. Saunders Elsevier.

CHILANGWA,B. 2004. *Zambia's orphans and vulnerable children.* Ministry of sport, youth and child development. Zambia.

DA's Policy, 2012: *Saving the lost generation*. The DA's policy on child-headed households. Available from [online] http://www.da.org.za/docs/613/ChildHeadedHouseholds_document.pdf [accessed on 12/10/12].

DEPARTMENT OF SOCIAL DEVELOPMENT. 2010. *National guidelines for statutory services to child-headed households*, Republic of South Africa.

DIJK, D.V.,& FRANCIEN, V. D., 2009. Supporting Child-Headed Households in South Africa: Whose Best Interests? *Journal of Southern African Studies*, 35: 4, 915- 927 [Online]. Available from: http://dx.doi.org/10.1080/03057070903313251 [Accessed:11/07/2013]

FOSTER, G., MAKUFA, C., DREW, R., & KRALOVEC, E. 1997. Factors leading to the establishment of child headed household: The case of Zimbabwe. *Zimbabwe health review*, 7(2), Nov.:155-168.

FRANCIS-CHIZORORO, M. 2007. *Orphanhood, childhood and identity dilemma of child headed households in rural Zimbabwe in the context of HIV/AIDS pandemic* [Online]. Available from: http://uaps2007.princeton.edu/papers/70431 [Accessed 10/07/2013].

GERMANN, S.E. 2005. *An explorative study of life and coping strategies orphans living in child headed household in high HIVAIDS prevalent city Bulawayo, Zimbabwe*. Doctorate thesis, University of South Africa.

ISANGEDIGHI, J.B., JOSHUA, M.T., ASIM, A. E & EKURI, E. E. 2004. *Fundamentals of research and statistics in education and social science.* Calabar: University of Calabar Press.

KOREVAAR, K . 2009. A Psychosocial description of young orphans living in child headed households. Master's thesis, University of Pretoria.

LEEDY, P.D. & ORMROD, J.E. 2001. *Practical Research: Planning and Designing.* 7th ed. New Jessey: Prentice Hall.

LUZZE, F. 2002. *Survival in child-headed households:* A study on the impact of world vision support on coping strategies in child-headed households in Kakuuto County, Rakai district, Uganda. University of Leeds: Oxford Centre for Mission Studies/World Vision.

MACLELLAN, M. 2005. *Child headed households: Dilemmas of Definition and livelihood rights.* African Studies Centre: Coventry University.

MAQOKO, Z. & DREYER, Y. 2007. Child headed households because of trauma surrounding HIV/AIDS. Department of practical theology, University of Pretoria. *HTS* 63(2), June: 718.

MEINTJES, H. HALL, K., MARERA, D. & BOULLE, A. 2010. Orphans of the AIDS epidemic? The extent, nature and circumstances of child headed households in South Africa*: AIDS Care,* 22 (1),Jan.: 40-49.

MOGOTLANE,S.M., CHOWKE, M.E., RENSBURG VAN G.H., HUMAN,S.P., & KGANAKGA,C.M. 2010. A situational analysis of child headed households in South Africa. *Curationis,* 33(3), Sept: 24-32.

NELSON MANDELA CHILDREN'S FUND. 2001. *Reports on: A study into situations and special needs of children in child-headed households.* [Online]. Available from: http://www.nelsonmandellachildrenfund.com/userDownloads/DOC1228132423.pdf [Accessed 30/12/2009].

NKOMO, N. 2006. The experience of children carrying responsibility for child headed households as a result of parental death due to HIV/AIDS. Magister Artium University of Pretoria.

PHILLIPS, C. 2011. *Child-headed households: a feasible way forward, or an infringement of children's right to alternative care?* [Online]. Available from: https://openaccess.leidenuniv.nl/handle/1887/17832 [Accessed 22/09/2011].

POLIT, F.D. & BECK, T.C. 2008. *Nursing research: Generation and Assessing Evidence for Nursing practice.* 8th ed. New York: Lippincott William & Wilkins.

ROALKVAM, S. 2005. *The Children left to stand alone. African journal of AIDS research* 4(3): December:211-218.

SACBC. 2009. Southern African catholic bishop's conference, *Child-headed households:* Briefing paper 209. [Online]. Available from: www.cplo.org.za. [Accessed 30/10/2010].

SKINNER, D., TSHEKO, N., MTERO-MUNYATI, S., CHIBATAMOTO, P., MFECANE, S., CHANDIWANA, B., NKMO, N., TLOU, S. & CHITIYO, G. 2004. *Defining orphaned and vulnerable children*: Social aspect of HIV/AIDS and health research programme occasional paper No. 2. Cape Town: HSRC, Press.

SLOTH-NIELSEN, J. 2004. *Realising the rights of children growing up in child headed households:* A guide to law policies and social advocacy. University of the Western Cape Community Law Centre.

STATISTICS SOUTH AFRICA 2011: *.P0302 Mid-year population estimate for 2011, Statistical release Pretoria.* [Online] Available from: www.statssa.gov.za. [Accessed on 11/03/12].

TSEGAYE, S. 2007. *HIV/AIDS and emerging challenge of children heading households*. [Online]. Available from: http://www.africanchildinfo.net/document/CHHSdiscussionpaper.pdf [Accessed 30/12/2009].

TSEGAYE, S. 2008. *HIV/AIDS, Orphans and child headed households: the Africa Child policy Forum.* [Online] http://www.africanchildinfo.net/documents/backgroundAWRC/Orphans%20and%20CHH%20ARCW%202008%20Background%20Paper.pdf [Accessed 30/1/ 2011].

UNAIDS. 2008. *The global HIV challenge: assessing progress, identifying obstacles, renewing commitment.* Report on the Global AIDS Epidemic 2008. http://data.unaids.org/pub/globalreport/2008/jc1510_2008_global_report_pp11_28_en.pdf

UNAIDS, 2010. Report on the Global AIDS Epidemic 2010, Geneva.

UNICEF, 2009a. *Progress Report for Children Affected by HIV/AIDS*, New York.

UNICEF, 2008. Community programmes help support impoverished child-headed households, *Malawi. [Online]. Available from: http://www.unicef.org/infobycountry/malawi_43083.html [Accessed 9/07/2013]*.

UNICEF. 2006. *Africa's orphaned and vulnerable generation-children affected by AID.* [online]. Available from: http://www.unicef.org/adolescence/file/AfricaOrphanandvulnerableGenerationChildrenAffectedbyAIDS.pdf. [Accessed 30/12/2009].

UNICEF. *Convention on the Rights of the Child. 1989. Article 1* (Definition of the child) [Online]. Available from: http://www.unicef.org/crc/files/Rights_overview.pdf [Accessed 02/06/2013].

UNISA. 2008. *Report on research conducted by the University of South Africa: A situational analysis of child-headed-households in South Africa.* Study 01. [Online]. Available from: http://www.google.co.za/url?sa=t&rct=j&q=methods%20of%20identifying%20child%20headed%20households&source=web&cd=9&cad=rja&sqi=2&ved=0CGcQFjAI&url=http%3A%2F%2Fwww.dsd.gov.za%2FNacca1%2Findex2.php%3Foption%3Dcom_docman%26task%3Ddoc_view%26gid%3D221%26Itemid%3D39&ei=mGZPUa73GYSjhge_-YEI&usg=AFQjCNFUdSdo5fxHNJ7W0vVmhCROjGQsOg
[Accessed on 25/03/2013].

WHO,. 2012. *Consequences of alcohol use*. [Online]. Available from: http://www.searo.who.int/LinkFiles/Facts_and_Figures_ch5.pdf [Accessed 12/10/12].

YOO, S., BUTLER, J., ELIAS, T.I., GOODMAN, R.M. 2009. The 6-step model for community empowerment. *Health Promotion Practice.*10 (2) 262.