

The Impact on Adolescent Reproductive Health of
Community-based Interventions for Supporting
Orphaned and Vulnerable Children in South Africa

May 2004

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BACKGROUND

In October 2000, the Nelson Mandela Children's Fund (NMCF) implemented the first phase of Goelama, a five-year, two phase project to test innovative approaches to address issues facing orphans and vulnerable children (OVC). This ended in March 2004. Depending on the outcome of the first phase, the program would be extended for a further two years to expand the successful elements of the project.

The program seeks to build on contemporary approaches and strategies for community-driven initiatives to improve the safety, health, and survival of OVC and youth aged 0-22 years. More specifically, Goelama intervention activities seek to:

- Improve the socio-economic livelihood skills for OVC through micro-finance and business development initiatives thus strengthening vulnerable households;
- Create sustainable community support systems for OVC;
- Impart skills essential for behavioral change to prevent new HIV infections, sexually transmitted diseases and unwanted or unplanned pregnancies, especially among adolescent OVC; and
- Stimulate an expanded and integrated local government response to the plight of OVC.

The NMCF worked with a range of strategic partners towards the implementation of phase one of the Goelama program and the role of each partner is defined below.

DEFINITION OF ROLES

Nelson Mandela Children's Fund

NMCF's role in the Goelama Project was to identify communities and Community Catalyst Organizations (CCOs) to work in those communities. Once relationships had been established, NMCF undertook the following functions to implement the Goelama Project:

- Issuing and managing financial grants to CCOs
- Developing the overall results and indicator framework for measuring impact of the project
- Managing all the grant making processes including overseeing the implementation of the grants
- Organizing training and capacity building for CCOs including regular technical seminars for networking and collaboration
- Providing overall management and monitoring of the project.

In providing financial support to the NMCF, USAID required the NMCF to provide regular information on program performance. However, NMCF lacked the research capacity to develop the required performance indicators and strategies for collecting and reporting on these indicators. To address this gap, NMCF contacted a locally based research organization, Development Research Africa (DRA) to assist with carrying out the baseline and endline surveys for their activities.

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The role of the Population Council was to provide technical support to NMCF and the CCOs who in turn would give technical support to the Community Based Organizations (CBOs) working at the grassroots level in the communities within the Goelama catchment areas. Technical support from the FRONTIERS and Horizons programs of the Population Council would enable NMCF to measure the impact of these interventions on selected household and individual level sexual and reproductive health indicators.

At the community level, NMCF utilized non-government organizations (NGOs) as CCOs to identify and implement the interventions. These CCOs required technical support to develop the skills and capacity to identify, design, implement, manage, monitor and report on the interventions. To the extent possible, it was agreed that the Horizons and FRONTIERS Programs would be relied upon to provide this technical support. At the outset, discussions with NMCF resulted in the definition of a two-level scope of technical support required from Population Council.

The first was at the NMCF level where the overall goal of the technical assistance requested from the Council was to ensure that the Performance Monitoring Plan (PMP) indicators and surveys were designed and carried out with the highest quality of research methods.

Specific activities under this goal included:

1. Reviewing and assisting with development of PMP indicators
2. Assisting with drafting of the scope of work and tender for the local research group to carry out the surveys
3. Assisting with the identification of an appropriate local research organization to conduct the surveys
4. Assisting the local research organization in designing the survey instruments, survey samples, fieldwork logistics, and training of data collectors
5. Monitoring field work to ensure that it remained of high quality
6. Monitoring data entry and cleaning
7. Assisting with data analysis and report writing

The second level of technical assistance was at the level of the CCOs and CBOs with an overall goal of ensuring that the interventions being implemented met the objectives of the program, and that they were of high quality.

Specific activities under this goal included:

1. Assisting with the development of capacity to assess, analyze and prioritize the needs of the target populations
2. Assisting with the development of the interventions to ensure that they were of good quality and met the needs and priorities of the target populations
3. Assisting with the development of capacity to monitor and report on intervention activities
4. Assisting to build and foster strong working relationships between groups of stakeholders at the grassroots level

MECHANISMS FOR PROVIDING TECHNICAL ASSISTANCE

Given that the senior professional staff for the Horizons and FRONTIERS Programs in South Africa were committed to other activities, it was agreed with the USAID Mission that a local staff with basic skills in research and a good knowledge of sexual and reproductive health and HIV/AIDS would be hired to work under the guidance of these two Programs. The local staff hire would require minimal supervision and support to implement the proposed technical assistance activities. This staff person would be based at the Population Council's offices in Johannesburg to facilitate easy consultation and guidance from other professional staff.

RESEARCH ACTIVITIES ACCOMPLISHED

- January-April 2001, Horizons/FRONTIERS drafted evaluation indicators for Goelama OVC activities.
- May-June 2001, Horizons/FRONTIERS assisted with (i) the tender advertisement for the baseline; (ii) reviewing applications; and (iii) the appointment of Development Research Africa (DRA) as the local agency that would conduct the baseline and endline studies.
- October 2001, Horizons/FRONTIERS attended a workshop to review and refine the evaluation indicators for OVC.
- Between December 2001 and March 2002, researchers conducted a household survey using a cluster random sampling design. A sample of 4,966 respondents included designated household heads (72 percent), spouses or permanent partners (23 percent) and children or stepchildren (3 percent) of the household head, and other relatives (2 percent). These respondents provided information on 29,338 household members (approximately six members per household) and included nearly 14,000 children. Respondents lived in eight districts, each of which is a local government unit under the jurisdiction of the District Council. The study sites and corresponding districts were Ehlanzeni in Mpumalanga Province; Mopani, Vhembe, and Capricorn in Northern Province; and Umkhanyakude, Mpukonyoni, Uthungulu and Mlalazi, Mthonjaneni, and Nkandla municipalities in KwaZulu Natal.

The household baseline study was specifically aimed at assessing: (i) the strength of households in coping with the impact of HIV/AIDS, (ii) the state and sustainability of community support systems, (iii) behaviour change for preventing new HIV/STI infections, (iv) expanded and integrated local government response to the plight of OVC, and (v) community priority needs in caring for OVC.

- Running concurrently with the household baseline was a baseline study conducted with nearly 5,000 youth aged 12 to 22 years using a cluster random sampling design. The youth component of the survey focused on the sexual and reproductive behaviors of young people in the Goelama intervention areas and factors that might influence these behaviors, such as schooling, orphanhood, health knowledge, and involvement in community activities.

- In February 2002, DRA presented interim baseline results from four KwaZulu-Natal sites to the Goelama Project Steering Committee. Data collection was still ongoing in the other four sites situated in Limpopo and Mpumalanga. A preliminary report, also based on KwaZulu-Natal data, had been drafted by DRA and was shared with the Steering Committee.
- Data collection was finally completed by DRA at the end of March 2002.
- Apart from the KwaZulu-Natal data mentioned above, the Population Council was not given the opportunity to provide input on the data cleaning, analysis and report writing by DRA. Horizons/Frontiers did not have direct access to DRA and the operating terms were such that any communication with DRA had to be channeled through NMCF. In August 2002, DRA produced three final reports for the baseline: (i) Household, (ii) Youth, and (iii) Synthesis, and submitted these to NMCF. NMCF in turn forwarded the reports to USAID.
- The USAID mission was not confident in the quality of the DRA baseline reports and NMCF was also doubtful of the accuracy of some of the indicators produced. As a result, Horizons/Frontiers was requested to: (i) assess the extent to which the evaluation indicators were measured in the baseline, (ii) assess the cleanliness of the data set, (iii) reanalyze the data and produce new baseline reports, (iv) clarify the research methodology adopted, and (v) assess the accuracy of indicators produced by DRA.
- In October 2002, the Council recruited a project manager to provide technical support to NMCF. Upon presentation of the workplan, in the discussion that followed, it became apparent that the Family Health International (FHI) IMPACT program was providing technical assistance to NMCF on intervention activities and monitoring of outputs. Later, NMCF hired a monitoring and evaluation (M&E) specialist who worked closely with FHI on monitoring the implementation of interventions and outputs. The bigger NMCF-Goelama Team worked jointly on program inputs, activities and documentation of outputs.
- Since providing technical assistance in interventions and monitoring is the FHI IMPACT program's area of expertise, Population Council involvement in providing this service would have amounted to duplication of effort. The Population Council's scope of work was then narrowed down to solely providing technical assistance on measuring outcomes.
- Datasets were obtained from DRA in November 2002. In December, the data sets were rigorously reviewed and were found to be adequately clean.
- Data analysis began in January 2003 and a draft youth baseline report was produced. At the end of March 2003, the first draft of the household report was circulated internally. In April, this was refined into a more complete and focused product by the team providing technical assistance. In May 2003, a revised household baseline report was circulated for wider internal review.
- At the end of June, a revised version of the youth report was circulated for internal review. In July 2003, the household report was submitted to the Frontiers regional director for review.
- In August 2003, drafts of the two reports had been adequately reviewed internally and were sent to Horizons/Frontiers Washington and USAID South Africa for external review.

- In October 2003, ten-page summaries of the baseline reports were circulated for comment then were finalized in November 2003 (Attached as Appendices 1 and 2).
- In January 2004, the National Department of Social Development and the Population Council, in partnership with the National Department of Health and USAID, held a workshop to develop a national operations research and intervention agenda focusing on OVC and youth. The workshop hosted 80 participants representing programs and researchers throughout South Africa. The output of this workshop was a series of operations research (OR) questions on defining and identifying OVC (3); integration of OVC activities (6); care and support (6); youth issues (3); voluntary counseling and testing (3). Out of the 21 OR questions produced, the workshop participants prioritized five research questions as listed below:
 - How can communities meet the psychosocial needs of OVC? Who can be involved and how?
 - How can children's vulnerability be defined and measured?
 - How can OVC be retained in schools and how can care and support be channeled through to the OVC who need it?
 - How effective are varying lifeskills approaches in achieving positive behavior change among youth?
 - What successful models of integration exist at different levels for application in OVC programs?

From the questions generated at the workshop, Horizons drafted two concept papers for potential research:

- Identifying sustainable community responses for providing psychosocial support to OVC
- Defining vulnerability and targeting appropriate youth care giver activities for orphans and vulnerable children.

DISSEMINATION AND UTILIZATION

As part of the technical support, the baseline results were disseminated widely at local and international levels. In total, 12 presentations were made for dissemination purposes:

- Preliminary results of the youth and household surveys were presented at a meeting in Mpumalanga, where USAID Washington and the South Africa Mission, FHI, NMCF and five representatives of three Mpumalanga-based CCOs were present.
- An oral presentation of the full baseline results was made to approximately 20 members of the technical reference group for Goelama interventions in January 2003.
- In January 2003, four oral presentations were made to approximately 50 representatives of Goelama CCOs and CBOs, and NMCF.
- In May 2003, the research and intervention lessons learned from Goelama were presented to about fifty South African researchers at the Perinatal Research Unit.

- In August 2003, a poster of the youth baseline results was presented at the South African AIDS Conference.
- In September 2003, presentations of the household and youth results were made at the USAID South Africa offices.
- In September 2003, one oral presentation and two posters of the findings were presented at the International Conference on STIs in Southern Africa (ICASA).
- In October 2003, the youth study results were presented at the Reproductive Health Priorities Conference.

CONCLUSION

Changes in management of Goelama presented a constant challenge in providing technical support to NMCF. Goelama changed management twice during the first year of collaboration and two more times in the second year. The technical assistance scope of work was revised each time management changed and the terms of collaboration were renegotiated. Moreover, because NMCF decided not to have an endline survey, Horizons/Frontiers was unable to extend technical assistance to the project. The Population Council technical support project came to an end in December 2003.

Appendix 1

VULNERABILITY AND INTERVENTION OPPORTUNITIES: RESEARCH FINDINGS ON YOUTH AND HIV/AIDS IN SOUTH AFRICA

The Nelson Mandela Children's Fund (NMCF) seeks comprehensive local solutions to address the negative effects of HIV/AIDS on children, adolescents, households, and communities. To this end, NMCF initiated the Goelama Project,¹ which uses a community mobilization strategy to catalyze action by local organizations and government bodies to prevent HIV infection and mitigate the socioeconomic impacts of the disease, particularly as they affect orphans and vulnerable children (OVC).

NMCF recognizes that in order to develop indigenous responses to the epidemic, it is important to conduct research to delineate the problem, identify opportunities for intervention, and measure the effectiveness of interventions prior to replication or scale-up. This summary highlights key findings from an assessment of reproductive and sexual health knowledge and behaviors among nearly 5,000 youth from eight districts in three provinces in South Africa where the Goelama Project is active: Mpumalanga, Limpopo, and KwaZulu Natal.

This research is part of a larger study of 29,338 members of nearly 5,000 households, which seeks to identify ways that government and communities can strengthen the socioeconomic capacity of households to care and support OVC. The research was commissioned by NMCF and conducted by Development Research Africa (DRA), with technical assistance from the Horizons and Frontiers programs. The youth component focuses on the sexual and reproductive behaviors of young people in the Goelama intervention areas and factors that may influence these behaviors, such as schooling, orphanhood, knowledge, and involvement in community activities.

Data Collection and Survey Sample

Between December 2001 and March 2002, researchers used a cluster random sample research design to conduct a household survey of youth 12 to 22 years old. Respondents were living in eight districts, each of which is a local government unit under the jurisdiction of the District Council. The study sites and corresponding districts were Ehlanzeni in Mpumalanga Province; Mopani, Vhembe, and Capricorn in Limpopo Province; and Umkhanyakude, Mpukonyoni, and Uthungulu, as well as Umlalazi, Mthonjaneni, and Nkandla municipalities in KwaZulu Natal.

In each household one youth was selected to be interviewed. In cases where there was more than one eligible youth, quotas established for age and sex guided the selection of the respondent.

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The final survey sample (2,451 males and 2,539 females) was representative of the larger population by sex, but was overrepresented by age for the age groups 16 to 18 and 19 to 22, and underrepresented for the age group 12 to 15. Almost all respondents were unmarried (98 percent). Over a third of youth 12 to 18 years old (38 percent) were orphans, meaning that they had lost one or both parents to death.² A higher proportion of these youth had lost their fathers (24 percent) than mothers (5 percent). Nine percent of youth reported that both parents were deceased.

Key Findings

Females and orphans are significantly more likely to be out of school compared to their counterparts. The study found that 8 percent of youth 12 to 18 years old were no longer attending school. Significant gender differentials were observed in school retention. Females were significantly more likely to be out of school than males (10 vs. 5 percent, $p < .001$). The reasons mentioned by all youth for dropping out of school were financial constraints (34 percent), pregnancy (23 percent), completion of high school education (18 percent), illness (5 percent), and poor school performance (4 percent). While males aged 12 to 18 years who were not in school were more likely to mention financial constraints (43 percent) compared to similarly-aged females (30 percent) as a reason for leaving school, females were more likely to leave school because of pregnancy (35 percent) compared to males (3 percent). All youth of school age (12 to 18 years old) who were no longer enrolled in school indicated that they were unemployed. In interpreting the results, it is important to note that the adolescents 12 to 14 years old were younger than the country's legal minimum age of employment (15 years) at the time of the survey. Also, the survey did not ask if the employable youth were involved in the informal sector or seeking employment or other means of generating income.

Orphans aged 12 to 18 years were significantly more likely to be out of school than non-orphans of the same age group (10 vs. 6 percent, $p < .001$). Orphans were also more likely to cite financial constraints (42 percent) and sickness (8 percent) as reasons for dropping out of school, compared to non-orphans (27 percent and 3 percent, respectively).

Fathers play a limited role as guardians of orphans and non-orphans. The mother was the most frequently mentioned guardian by the youth surveyed (35 percent). Although most youth (62 percent) said that both parents were alive, only a third (35 percent) of these youth reported that both parents were guardians. In addition to the mother, other key guardians for orphans were a grandparent or other relative. Figures 1 and 2 illustrate the guardianship for both orphans and non-orphans.

Figure 1: Guardianship of orphaned youth 12 to 18 years old (n = 3,314)

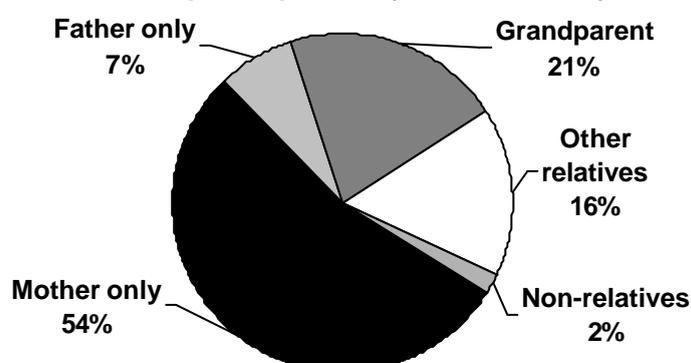
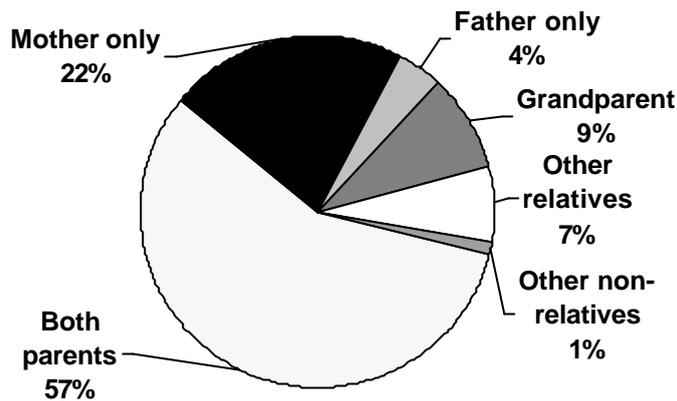


Figure 2: Guardianship of non-orphaned youth 12 to 18 years old (n = 3,314)



Most youth do not report having stigmatizing attitudes toward people living with HIV and AIDS, but some feel that orphans are treated badly in the community. The vast majority of youth felt comfortable traveling in the same vehicle with people living with HIV and AIDS (85 percent) and disagreed with the statement that HIV-infected people should be isolated (85 percent). A smaller proportion, yet still a majority (54 percent), disagreed with the statement that HIV-infected people should not sell food.

When asked about the stigmatization of orphans, a quarter of youth in the sample felt that orphans are treated differently from non-orphans. Only 2 percent thought that orphans are treated in a better way, while the vast majority felt that orphans are treated worse, citing the following examples: not being fed or looked after (48 percent), used as servants or laborers (40 percent), physically abused (30 percent), verbally abused (26 percent), teased in school (12 percent), rejected (11 percent), and sexually abused (10 percent). Because opinions may be based on hearsay rather than experience and observation, researchers also asked orphans this question. A similar proportion of orphans (25 percent) said that they were treated differently, and in most cases worse, than non-orphans. On several measures, a slightly greater proportion of orphan respondents compared to non-orphan respondents reported that orphans are teased at school (16 vs. 10 percent), isolated (23 vs. 20 percent), and experience rejection (13 vs. 10 percent). But orphan respondents were less likely to state that they are used as servants (33 vs. 45 percent) and not fed or looked after (45 vs. 50 percent), compared to non-orphan respondents. While both perspectives support the existence of negative treatment of orphans by the community, further investigation is required to gain insight into the community dynamics underlying differential treatment of orphans.

Reproductive and HIV/STI-related knowledge and awareness are uneven among youth.

Although not sufficient alone, knowledge is an important factor in changing risk-taking behavior. The study found that awareness of HIV/AIDS was high (97 percent), although knowledge of ways to prevent HIV infection was skewed toward consistent condom use. Eighty-nine percent mentioned this HIV prevention method, but abstaining from sex and staying faithful to one partner were mentioned by much smaller proportions of youth (32 percent and 23 percent, respectively). Other ways to prevent HIV that were mentioned included using gloves (22 percent), avoiding blood contact (22 percent) and not sharing razors and/or needles (11 percent). Less than 5 percent of youth said they didn't know how to prevent HIV or mentioned an incorrect method. Eighty-five percent were aware that a pregnant woman could transmit HIV to her baby before and during childbirth, while two-thirds (67 percent) knew about the potential for transmission during breastfeeding. Just above half of youth (57 percent) knew that something could be done to prevent an HIV-positive mother from transmitting HIV to her unborn child.

There were significant gender differences in youth awareness of mother-to-child transmission of HIV and its prevention. Females were more aware than males that a pregnant woman can

transmit HIV to her baby before and during childbirth (87 vs. 84 percent; $p < .01$), that HIV can be transmitted during breastfeeding (72 vs. 61 percent; $p < .001$), and that something can be done to prevent an HIV-positive mother from transmitting HIV to her unborn child (64 vs. 51 percent; $p < .001$). Knowledge of the existence of an HIV test (79 percent) and dual protection methods (86 percent) was also high and showed significant gender differences ($p < 0.001$). Females were more likely to report being aware of the existence of an HIV test (82 percent) and dual protection methods (87 percent) than were males (76 percent and 85 percent, respectively). Overall, females were more aware of how to become infected with HIV (mean knowledge score = 1.95) or how to avoid HIV infection (mean knowledge score = 1.87), compared to males (mean knowledge scores = 1.77 and 1.67, respectively).

Sixty-three percent of youth had heard of sexually transmitted infections (STIs). Twenty-one percent of all youth did not know any STI symptoms in men, and 30 percent did not know any STI symptoms in women. Another 17 and 14 percent of youth mentioned incorrect STI symptoms in men and women, respectively.

Contraceptive awareness among youth was higher for the male condom (94 percent) than for the injection methods (74 percent), the pill (66 percent), and the female condom (58 percent). Other contraceptive methods, such as the intrauterine contraceptive device (IUD), female sterilisation, male sterilisation, diaphragm, foam/jelly, emergency contraceptives, lactation amenorrhea, rhythm, and withdrawal were known by less than a quarter of youth each. The menstrual cycle was not well understood by respondents, as indicated by the fact that only 7 percent knew the correct time in the cycle when a woman is most likely to get pregnant. There were significant gender differences in knowledge of most contraceptive methods. For example, females were significantly more aware than males of the pill (72 vs. 61 percent; $p < .001$); IUD (18 vs. 6 percent; $p < .001$); injection (79 vs. 68 percent; $p < .001$); and female sterilisation (27 vs. 14 percent; $p < .001$). Males were significantly more aware than females of rhythm (9 vs. 5 percent; $p < .001$) and withdrawal (28 vs. 16 percent; $p < .001$).

Males initiate sex at an earlier age than females and are more likely to report more than one partner in the previous year. Forty-five percent of youth respondents 12 to 20 years old reported ever having sex in their lifetime ($n = 2,235$). More male respondents had had sex (47 percent) than female respondents (42 percent). Three times as many males (24 percent) compared to females (8 percent) had had sex before reaching 15 years of age. This gender differential prevailed throughout adolescence: 48 percent of males and 35 percent of females had had sex before reaching 18 years of age. Eight percent of sexually experienced youth had had no sexual partners during the 12-month recall period, and males were significantly more likely than females to report being abstinent during this time (11 vs. 4 percent; $p < .001$).

About one third (31 percent) of sexually experienced youth had had more than one sexual partner during the 12 months preceding the survey. Females were significantly less likely than males to report having multiple partners in the previous year (13 vs. 49 percent; $p < .001$), and were significantly more likely than males to report having had only one partner in the past year (83 vs. 40 percent; $p < .001$). Sexually experienced youth who belonged to a religious group were significantly less likely to have had multiple sexual partners during the past year than were youth who did not belong to a religious group (28 vs. 41 percent; $p < .001$).

Current contraceptive use is high among sexually experienced youth. Youth were asked if they or their partner had ever used and were currently using various contraceptive methods (see Table 1). Two-thirds of sexually experienced youth reported that they were currently using a contraceptive method. The male condom was the most popular method reported for current and ever use by both

male and female youth. Not surprisingly, a significantly higher proportion of females than males reported the use of injectables, while a higher proportion of males compared to females reported the use of condoms.

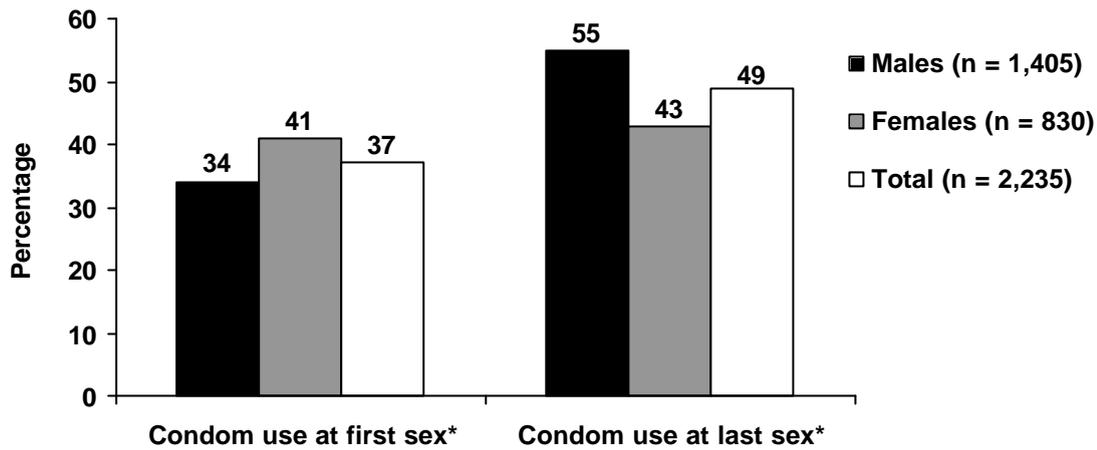
Table 1: Ever and current contraceptive use among sexually experienced youth (%)

Contraceptive methods	Ever use		Current use	
	Males (n = 1,161)	Females (n = 1,074)	Males (n = 1,161)	Females (n = 1,074)
Male condom	69*	54	59*	43
Injectables	23*	46	19*	36
Pill	9	13	7	6
Withdrawal	12	10	6	5
Any method	78	78	69	67

* Any statistically significant differences between males and females ($p < .001$)

Females lag behind males on several measures of condom use, despite risks. Among sexually experienced youth, the proportion using a condom at first sexual intercourse was low (37 percent) (Figure 3). Although females were significantly more likely to have used condoms than males at first sex, this pattern is reversed at last sex.

Figure 3: Condom use at first and last sex among males and females (%)



* Statistically significant differences between males and females ($p < .001$)

Consistent condom use during every act of intercourse among sexually experienced youth was relatively low (23 percent). Table 2 indicates that youth who reported having one partner in the past year were significantly more likely to have never used a condom and less likely to use a condom consistently compared to youth who reported more than one sexual partnership in the preceding year. Females reported lower consistent use of condoms regardless of the number of partners reported in the past year.

Table 2: Condom use with partner(s) according to the number of partners in the preceding year and gender (%)

	One partner		Multiple partners	
	Males (n = 462)	Females (n = 885)	Males (n = 559)	Females (n = 147)
Never*	31	44	23	37
Consistent*	28	20	26	14

* Statistically significant differences between males and females ($p < .001$)

Females were more likely to report they had ever been pregnant (47 percent) than males were likely to report they had made a girl pregnant (10 percent). Of all reported pregnancies, 93 percent were unplanned. In addition, a significantly greater proportion of females reported experiencing STI symptoms in the past three months than males (14 vs. 10 percent; $p < .05$). More than half (58 percent) of the youth who reported experiencing an STI symptom in the past three months sought treatment from a clinic, doctor, or hospital. There was no significant difference by sex in health seeking behaviour. Only half (51 percent) of those with an STI symptom notified their partner, and 32 percent were aware that their partner sought treatment. A significantly greater proportion of females than males reported that the partner sought treatment (36 vs. 28 percent; $p < .05$).

Both females and males report pressuring a partner to have sex, but females are twice as likely to have been physically forced to have sex. The study used a range of questions to explore motivations and pressure for having sex. As shown in Table 3, 25 percent and 18 percent of sexually

experienced males and females, respectively, reported that they have used verbal persuasion to convince a reluctant partner to have sex. Much lower figures were reported for engaging in sex for material gain or because of physical force, although twice as many females reported being the victims of forced sex than males.

Table 3: Sexual coercion among sexually experienced males and females (%)

	Ever been physically forced to have sex**	Ever been given money or gift to have sex*	Ever convinced reluctant partner to have sex**	Ever given money or gift to have sex
Males (n = 1,156)	3	3	25	3
Females (n = 1,071)	6	5	18	2
Total (n = 2,228)	4	4	21	3

* Statistically significant difference between males and females ($p < .05$)

** Statistically significant difference between males and females ($p < .001$)

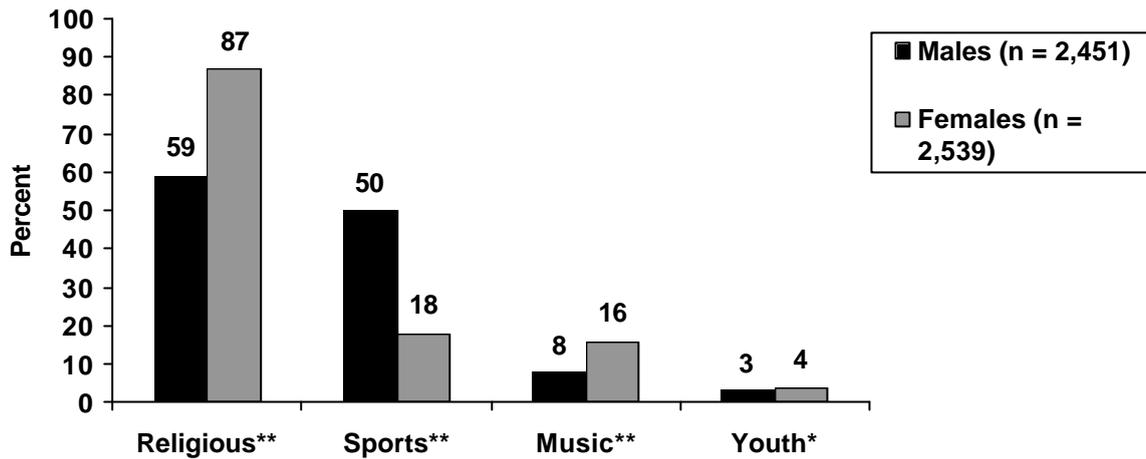
Many youth are involved in religious and sports activities, but participation in other community groups is minimal. Community groups provide opportunities for young people to learn about reproductive health and sexually transmitted infections, including HIV, and to participate in prevention and care activities. The researchers asked youth about their involvement in different kinds of groups to gauge the potential for integrating HIV/AIDS activities into ongoing, organized groups.

As Figure 4 indicates, apart from religious and sports groups, youth participation in music and dance, and in youth community groups,³ was low. The figure also highlights significant differences by sex in youth participation by type of group. Less than 1 percent of all youth reported that they were members of other community groups such as stockvels,⁴ burial societies, community gardening groups, sewing groups, development committees, community health organizations, and parent-teacher associations, or school governing body groups.

Youth who were current group members were asked how many times a month they participate in meetings and other activities. On average, youth members of sports groups participated most often (13 times per month), followed by members of music and dance groups (9 times per month). The figures for youth community groups and religious groups were six times per month and four times per month, respectively.

Sports and religious community groups have different strengths as entry points for HIV/AIDS and reproductive health interventions. For example, religious groups have relatively more members than other groups and sports groups have half the membership of religious groups but tend to have more regular meetings per month. Other groups, such as music and dance groups have few members but a high frequency of participation among its members, and other skills development and livelihood groups such as sewing, gardening, and development and community health groups, should be strengthened and promoted to reach more youth.

Figure 4: Current youth group membership (%)



* Statistically significant difference between males and females ($p < .01$)

** Statistically significant differences between males and females ($p < .001$)

Youth report low participation in HIV-related community activities. Only 3 percent of youth had ever participated in an HIV awareness raising campaign or distributed educational materials. Less than 2 percent of youth had participated in raising awareness of HIV voluntary counseling and testing (VCT) services, or in referring others to VCT or other related health services. In total, 5 percent of youth had ever been involved in any type of HIV-related activity, and there were no significant gender differences in youth participation in such activities. Youth who belonged to a religious group were more likely to have ever participated in any of the activities (5 percent) than were those who did not belong to a religious group (3 percent).

Many youth help needy community members, although ongoing assistance is less common.

To assess youth participation in the provision of assistance to needy members of their community, males and females were asked how often they provide assistance in various activities. As Table 4 indicates, apart from fixing things for neighbors, the majority of both males and females provided some support in caring for children, preparing or giving food, shopping or running errands, and doing household tasks. However, a significantly greater proportion of females than males said they provide frequent support for various domestic activities.

Table 4: Provision of services to neighbors and community members by youth (%)

Activity	Males (n = 2,450)	Females (n = 2,539)	All (n = 4,989)
Care for neighbors' children*			
Sometimes	44	43	44
Often	8	14	11
Prepare or give food to neighbors*			
Sometimes	49	46	48
Often	3	13	8
Shopping or run errands			
Sometimes	53	51	52
Often	23	24	24
Do unpaid housework *			
Sometimes	43	47	45
Often	8	11	10
Fix things for people*			
Sometimes	38	33	36
Often	4	5	4

Program and Policy Implications

Education is a valuable means of empowering youth—without proper qualifications, the chances of employment are remote. Schools can be an important setting for reaching youth on HIV and pregnancy prevention. To empower youth in the fight against HIV/AIDS, the South African government has embarked on a national life skills program that begins in secondary schools and is now expanding to primary schools. Those who drop out of school not only miss out on formal education but also on essential life skills development. Schools also provide supervised time and offer students an alternative to high-risk activities.

Lower rates of school enrollment and retention among females and orphaned youth highlight their potential disadvantage in taking advantage of economic opportunities and in learning essential skills for HIV and pregnancy prevention. Therefore, greater efforts should be made to help these vulnerable groups stay in school and to target programs for school dropouts on income generation, vocational training, and sexual terms negotiation skills to those who have already dropped out.

The results also reveal a need for school and community-based strategies to provide appropriate reproductive health information and services for youth. Of concern is the fact that many youth failed to mention abstaining from sex and being faithful to one partner as ways of preventing HIV infection. Although consistent condom use was well known, it was not well practiced by sexually experienced youth. Therefore, programs should promote primary abstinence for sexually inexperienced youth, and secondary abstinence and consistent condom use among sexually active youth. Messages that promote faithfulness to one partner need to be appropriately crafted and targeted, given the dynamic nature of relationships among youth. Youth should be taught to correctly assess personal risk to HIV/STI infection.

Youth who experience forced sex are exposed to the immediate risk of infection and unwanted pregnancy. Furthermore, sexual coercion and exchanging sex for material gain may limit youths' ability to negotiate safer sex. A UNFPA study (UNFPA 2000) looked at different forms of sexual motivation and pressure, including verbal persuasion, accepting and offering monetary or material compensation, and use of physical force. Research in 1999 on the economics of sex among

adolescents 14 to 22 years old in the Durban metropolitan area found that while youth were reluctant to acknowledge the impact of gifts on their own sexual behaviour and activities, they affirmed that gifts do play a role in negotiating sexual terms and in altering expectations of sexual activity (Kaufman and Stavrou 2002). The researchers found that reported rates of sexual exchange sex were relatively low, although a significant proportion of males and females said they had persuaded a reluctant partner to have sex. The existence of sexual persuasion as well as forced sex, unplanned pregnancy, and unprotected sex among young females and males highlights the need for comprehensive programs for all youth that address peer and partner pressure, sexual rights, and gender-based violence in addition to HIV/AIDS and STIs.

Findings from a study on transitions into adulthood in South Africa suggest that connectedness of youth to stable, supportive, and consistent family and community relationships may be a factor in determining the sexual and reproductive health behavior of youth (Horizons 2001). Studies that have included multidimensional community measures often find that structures of opportunities within communities are important to children and adolescents' development. Moreover, the effects of community structures on adolescents are mediated by family processes and by a family's ability to draw on resources within the community (Kaufman et al. 2002).

High levels of youth membership in religious groups and the reported frequent participation in sports groups provide some evidence of community connectedness, and may offer an entry point for community groups focused on HIV/AIDS or reproductive health to reach more youth with information and services. Moreover, the capacity of sports and religious groups to mobilize youth to play a leading role in HIV-related community interventions, such as promoting VCT, increasing awareness of orphan support programs, and helping to reduce stigma among orphans, should also be explored.

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¹ "Goelama" is a Tswana term for nurturing and caring.

² Forty-five percent of older youth had also lost one or both parents. For the purpose of this report, unless otherwise stated, an orphan refers to a male or female 12 to 18 old who had lost one or both parents.

³ Youth community groups refer to groups of youth who meet regularly to address challenges facing peers and other community issues.

⁴ Refer to indigenous community savings and income-generating schemes that were common during the apartheid era for black economic empowerment.

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Appendix 2

CHALLENGES FACED BY HOUSEHOLDS IN CARING FOR ORPHANS AND VULNERABLE CHILDREN

South Africa has seen a rapid increase in HIV prevalence among the general population over the past 10 years, from less than 1 percent in 1990 to 20 percent in 2001 (UNDP 2002). As the HIV/AIDS epidemic increases, so do the number of orphans and vulnerable children (OVC). In 2002, an estimated five million people (approximately 12 percent of the population) were living with HIV/AIDS (Steinberg et al. 2002). Because of the average 10-year period between infection and death, even if HIV prevalence declined rapidly, South Africa would still experience an increasing orphan burden for many years to come. Projections show that by 2010, 16 percent of all children in South Africa will be orphans, with more than 70 percent orphaned by AIDS (Dennis, Ross, and Smith 2002).

The Nelson Mandela Children's Fund (NMCF) seeks comprehensive local solutions to address the negative effects of HIV/AIDS on children, adolescents, households, and communities. To this end, NMCF initiated the Goelama Project,¹ which uses a community mobilization strategy to catalyze action by local organizations and government bodies to prevent HIV infection and mitigate the socioeconomic impacts of the disease, particularly as they affect OVC. NMCF recognizes that in order to develop indigenous responses to the epidemic, it is important to conduct research to delineate the problem, identify opportunities for intervention, and measure the effectiveness of interventions prior to replication or scale-up.

This summary highlights key findings from a study of over 29,000 members of nearly 5,000 households in eight study sites to identify ways that government and communities can strengthen the socioeconomic capacity of households to care for and support OVC. The research was commissioned by NMCF and conducted by Development Research Africa (DRA), with technical assistance from the Horizons and Frontiers programs. The eight predominantly rural study sites were situated in the provinces of Mpumalanga, Limpopo, and KwaZulu Natal.

Data Collection and Survey Sample

Between December 2001 and March 2002, researchers conducted a household survey using a cluster random sample research design. Respondents lived in eight districts, each of which is a local government demarcation unit under the jurisdiction of the District Council.

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The study sites and corresponding districts are Ehlanzeni in Mpumalanga Province; Mopani, Vhembe, and Capricorn in Northern Province; and Umkhanyakude, Mpukonyoni, Uthungulu and uMlalazi, Mthonjaneni, and Nkandla municipalities in KwaZulu Natal.

In each household one respondent, the household head was selected to be interviewed. In the temporary absence of the head of the household, the person responsible for the daily decision making, buying food, or taking care of the children was interviewed. The final sample of 4,966 respondents included designated household heads (72 percent), spouses or permanent partners (23 percent) and children or stepchildren (3 percent) of the household head, and other relatives (2 percent). These respondents provided information on 29,338 household members (approximately six members per household) and included nearly 14,000 children. Data show that 52 percent of the household heads were male. Household heads ranged in age from 14 to 106 years, with a mean age of 51 years.

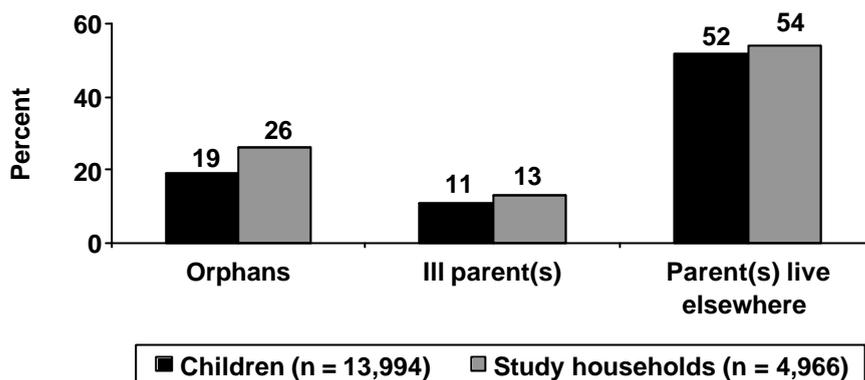
Key Findings

Nearly one in five children in the study population is an orphan. Children have multiple needs—physical, material, intellectual, and psychosocial—and it is important to identify groups of children whose social circumstances may affect the extent to which these needs are met. Respondents provided information on the orphanhood status of children 18 years old or younger living in the household. Five percent of children had lost their mothers and more than three times as many (16 percent) had lost their fathers; 2 percent had lost both parents. As indicated in Figure 1, 19 percent of all children were maternal, paternal, or double orphans and live in more than a quarter of study households. Living arrangement patterns among orphans show that 39 percent lived with the grandparent(s) and 16 percent lived with a parent in the grandparent's house.

In addition to orphanhood, parental illness is a significant reality in Goelama areas: 13 percent of households had at least one child whose parents experienced a serious illness in the past 12 months. Overall, 11 percent of children in the sample had a mother, father, or both parents who had been seriously ill during the 12-month period (see Figure 1). More children had sick mothers (8 percent) compared to sick fathers (6 percent). Only 1 percent of children had both parents experiencing serious illness.

Figure 1 also indicates that one or both parents did not live with more than half (52 percent) of the children in the study sample. Children were more likely not to live with their fathers (54 percent) than with their mothers (19 percent). Thirty-nine percent of children did not live with at least one natural parent, and 13 percent did not live with both natural parents.

Figure 1: Vulnerability of children



Orphanhood and parental illness affect school enrollment and attendance. Seven percent of children in the study households 7 to 18 years old were not enrolled in school, mainly due to financial difficulties (50 percent), disability (14 percent), personal illness (10 percent), and pregnancy (8 percent). Orphans were more likely to have dropped out of school compared to non-orphans (9 vs. 6 percent, $p < .001$), with financial difficulties as the main reason. Children with seriously ill parents were more likely to have dropped out of school (8 percent), compared to children with healthy parents (6 percent). Similarly, children affected by parental illness were more likely to have stopped attending school because of care giving (5 percent), poor behavior (14 percent) and poor school performance (12 percent), compared to children whose parents were healthy (3, 4, and 7 percent, respectively). Cross tabulations of education by age shows that many children were lagging behind their education cohort, suggesting either late onset of education or high failure rates.

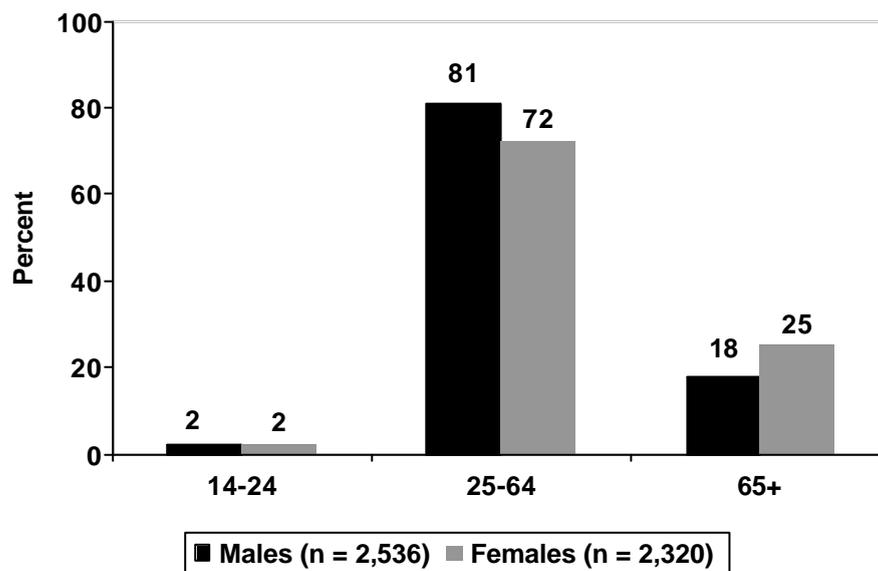
Many children are not fully immunized. Almost all children age six years or younger (97 percent) living in the household had immunization cards (known as the “road to health” cards), yet only 63 percent had received measles and DPT injections. Children affected by serious parental illness were less likely to receive both measles and DPT injections (59 percent) than were those whose parents were healthy (64 percent). The study findings also indicate that in only 17 percent of households, respondents noted that the youngest child (age 18 years or younger) had eaten food from three food groups—starches, fruits and vegetables, and proteins—in the week prior to the study. Respondents from households that had experienced parental illness during the 12 months preceding the survey were more likely to report that the youngest child (age 18 years or younger) was fed food from all three food groups in the week prior to the study, compared to households that did not have children with seriously ill parents (19 vs. 17 percent; $p < .01$). There were no statistically significant differences in the consumption of foods from the three food groups by orphaned children compared to non-orphans as reported by study respondents.

Female-headed households are more likely to be poor and include orphans than male-headed households. About half of the households surveyed (48 percent) were headed by females. The data indicate that female-headed households were significantly more likely to report that they earned monthly income at or below the poverty line² compared to male-headed households (74 vs. 61 percent; $p < .001$). The study findings also show that female-headed households were more likely to have a parent living away from home (62 percent), compared to male-headed households (38 percent). This is largely due to higher migration rates among males compared to females. Sixty-eight percent of female-headed households included children who were orphaned, compared to 32 percent of male-headed households ($p < .001$).

A substantial number of household heads are elderly and have had no schooling. The households in Goelama sites showed strong family cohesiveness. On average, over two-thirds (68 percent) of household members were immediately related, and almost a third (30 percent) had an extended family relationship with the household head. Thirty-eight percent of children lived with one or more grandparents. Only 2 percent of children lived with non-relatives.

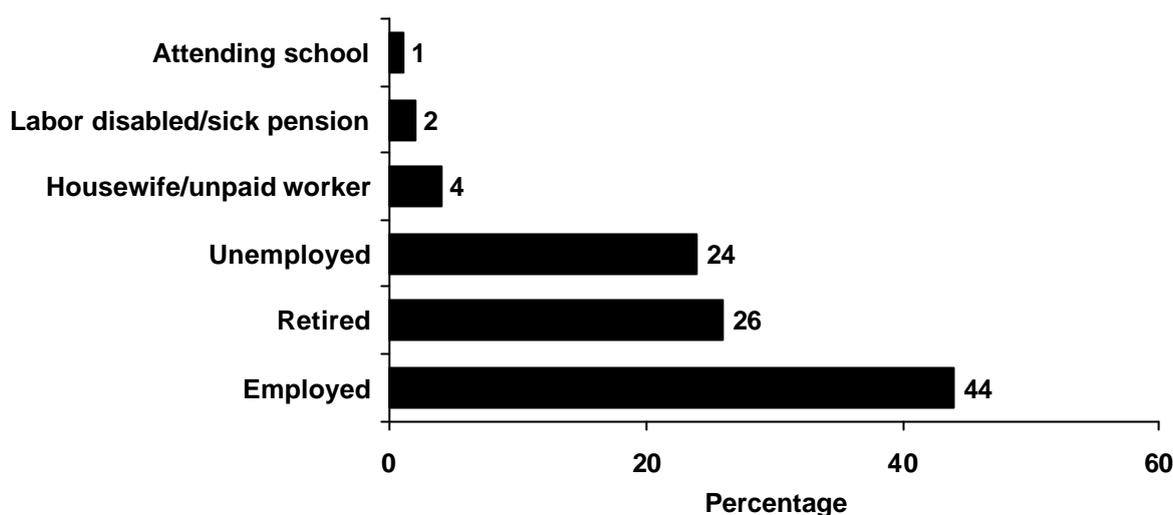
When examining household headship, the study found that 21 percent of household heads were 65 years or older (Figure 2). At the opposite end of the age spectrum, 2 percent of study households were headed by youth 14 to 24 years old.

Figure 2: Age profile of household heads



About a third (35 percent) of household heads had no schooling, and enrollment in adult education programs was very low (0.1 percent). As Figure 3 indicates, almost half of household heads (44 percent) in the study were gainfully employed, and 24 percent said they were unemployed. Consistent with the finding that a large proportion of elderly are heading households, 26 percent of household heads were retired.

Figure 3: Occupation of household head



The majority of households earn a monthly income at or below the poverty line. The findings reveal that the socioeconomic status of households was generally low, which may be partly due to the rural selectivity of the sample: 76 percent of the sampled households were in rural areas. Two-thirds of households reported an average monthly income of R800 or less. The proportion of households with working members who earned income was also low; only 34 percent of households reported that they received income from full-time employment, 13 percent from part-time, and 8 percent from casual employment. Despite the low contribution of employment to household income, reported involvement in income-generating activities was also low: just 16 percent of households receive income from self-employment.

Government grants make a significant contribution to household income. On average, income from government grants contributed to more than half of total household income. As shown in Table 1, grants contributed a mean proportion of 53 percent and a median proportion of 83 percent of household income per month for the 3,758 respondents who provided information on household income. Existing access³ and new applications⁴ to grants are presented in Table 1. Apart from old age pensions, reported access to other grants was low. Less than a third of eligible households reported that they received child support, foster care, disability, and care dependency grants. The proportion of households with members who had submitted new applications was also low.

Table 1: Access to government grants

Benefit	Value/ percentage per month	Existing access among eligible households	New applications
Mean % of grants to household income	53%	NA	NA
Median % of grants to household income	83%	NA	NA
Child support grant (n = 3,174)	R160/US\$22	28%	7%
Care dependency grant (n = 657)	R700/US\$95	5%	2%
Old age pension (n = 1,630)	R700/US\$95	83%	5%
Disability grant (n = 711)	R700/US\$95	32%	3%

The "n"s refer to the number of eligible households for each grant.
NA = not applicable

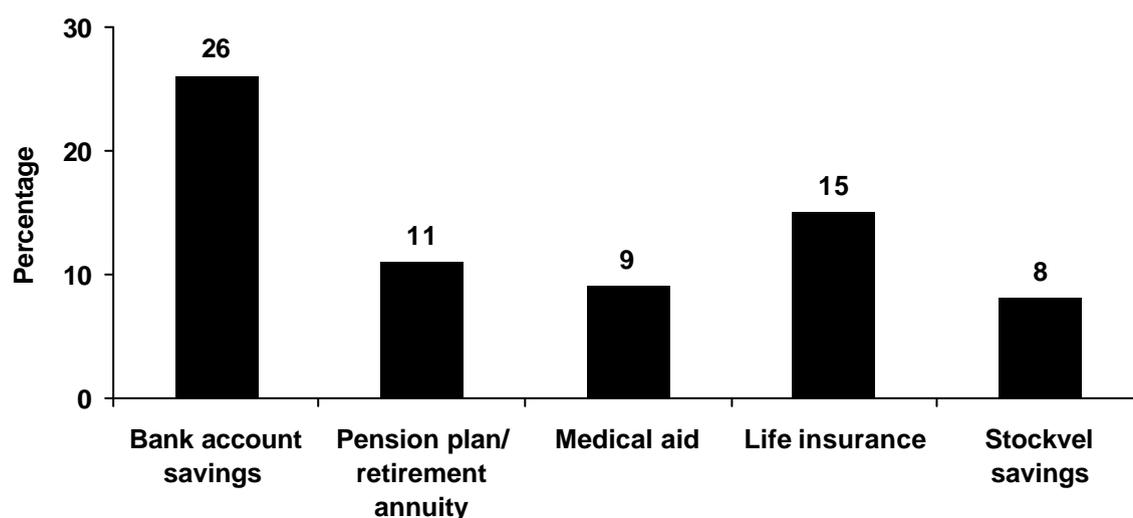
Households experience events that can deepen existing poverty. The study findings highlight the extent to which households experienced destabilizing events that can deepen the poverty of already poor households. Commonly mentioned events that occurred during the two-year period prior to the survey were death (21 percent), serious illness or injury (15 percent), loss of regular income (10 percent), theft, fire or property grabbing (9 percent), and loss of crops and/or livestock (5 percent). Other events—cut-off of remittance, abandonment or divorce, cut-off of a government grant, and business failure or bankruptcy—were each mentioned by 2 percent or less of household respondents.

Households with children whose parents had fallen ill during the 12 months prior to the study were significantly more likely to earn income at or below the poverty line, compared to households with healthy parents (74 vs. 66 percent; $p < .001$). A similar difference with regard to income status was found when comparing households with and without orphans: 69 vs. 66 percent ($p < .05$).

Merely citing the proportion of households that experienced death in the past two years does not give the full extent of bereavement and loss that the households suffer through death. Of all households that experienced death during the recall period, 12 percent lost two members and 5 percent lost three or more household members. Strategies taken to cope with death and serious illness included asset depletion (14 and 67 percent, respectively) and increased indebtedness (21 and 30 percent, respectively).

Many households are unable to plan for adverse and destabilizing events because of a lack of assets. The study found that the majority of households (61 percent) did not have any financial assets. As indicated in Figure 4, approximately a quarter (26 percent) of households had a savings account, but fewer households had invested in life insurance, medical insurance, and pension plans as well as stock/vef savings.

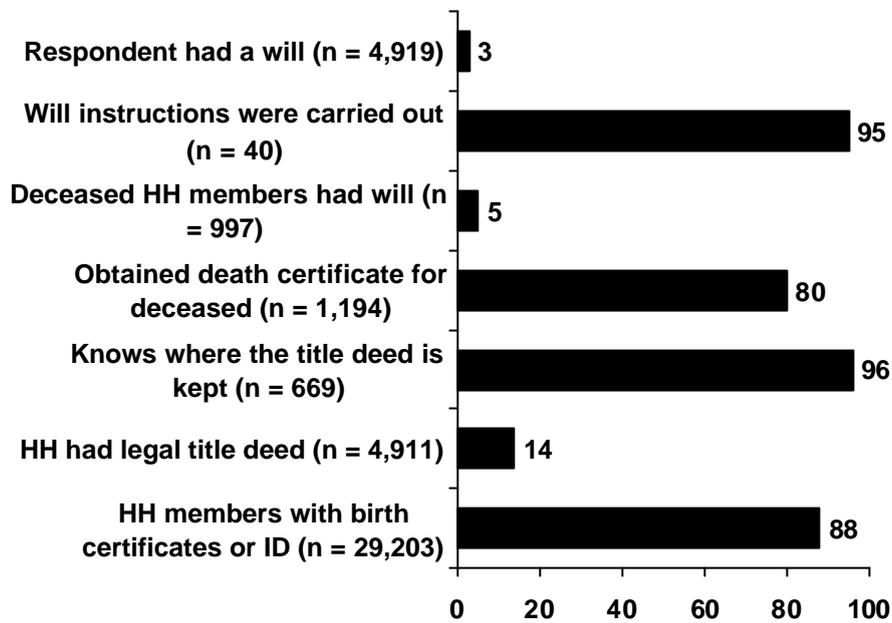
Figure 4: Financial assets of households



The legal preparedness of households is uneven, thereby affecting grant applications and inheritance rights. Figure 5 shows that registration of births and deaths was high. Birth registration is a prerequisite to attaining the national identity document, which in turn facilitates applications for

grants. Death registration precedes inheritance and may be a barrier in fulfilling succession planning. But only 3 percent of respondents had a will, and only 14 percent of households had a title deed to the house they were living in at the time of the survey.

Figure 5: Legal preparedness of households (%)



Apart from religious and burial groups, membership in community groups is low. The study found that apart from membership in religious groups (79 percent) and burial societies (37 percent), household respondents' affiliation with community groups was low. When asked about participation in the last month, the reported frequency of participation in group activities was low for religious and burial groups. However, as indicated in Table 2, groups that did not have many members in the community, such as sports, music, and dance groups had the advantage of engaging members in more meetings (six to eight times) per month.

Table 2: Participation in community groups by household respondents (n = 4,966)

Community group	Membership (%)	Participation per month
Religious	79	1
Burial societies	37	1
Sports	2	8
Music and dance	<2	6
Stockvels	6	1

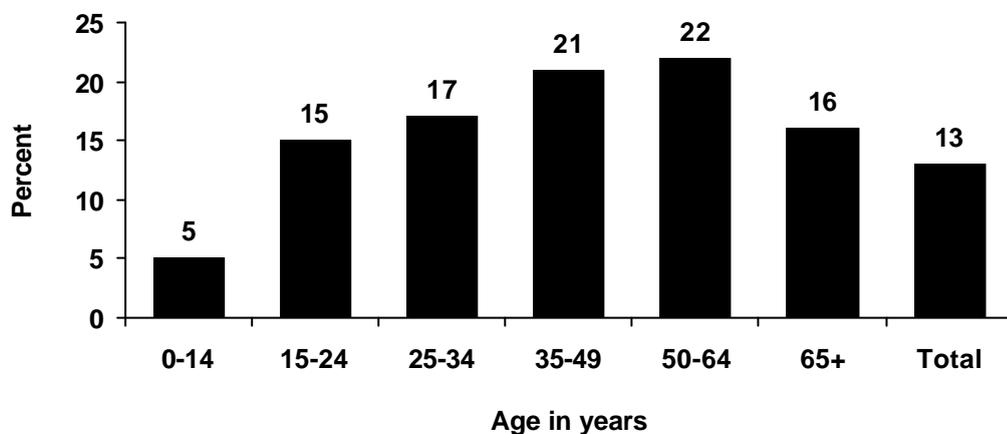
Most respondents have positive perceptions of community connectedness and help neighbors when needed. To measure social capital and community connectedness, respondents were asked if they agreed or disagreed with specific statements. Fifty-nine percent of respondents felt they had many friends in the neighborhood. A higher proportion of respondents (77 percent) felt that the children in the household had many friends in the community. For these two measures there were no significant differences between respondents living in households with orphans and those respondents living in households without orphans. More than four in five respondents felt most adults in the community would help the respondent's family members if they were in trouble (87 percent). Although high, respondents from households with orphans were slightly less likely to agree with the statement compared to respondents belonging to households with no orphans (87 vs. 88 percent, respectively; $p < .001$). Most respondents felt that people in their neighborhood work together to deal with issues affecting them (84 percent), and 77 percent felt that people in the neighborhood trust one another. Generally, most respondents felt well rooted in their communities, and only 11 percent reported that they would be much happier in another community.

To assess household respondents' participation in providing assistance to members of their community, respondents were asked to describe how often they provide assistance with various activities. More than half of respondents provided some support in caring for children (59 percent), supporting neighbors during funerals (95 percent), preparing or giving food to neighbors (70 percent), and helping neighbors when they were sick (73 percent). Other activities included shopping for neighbors (51 percent) and lending money (52 percent) or food and goods to neighbors (58 percent). Fewer respondents were involved in making/fixing things (40 percent) and doing unpaid housework (44 percent) for neighbors.

Few household members participate in ongoing care and support of seriously ill

community members. Reported participation of household members in caring for and supporting seriously ill community members outside the household was low (13 percent). A significantly greater proportion of females provided care and support to the seriously ill, compared to males (14 vs. 11 percent; $p < .001$). As shown in Figure 6, the burden of care falls mostly on older adults age 35 and over. As the number of people who need care increase, more family members are compelled to render care and support services. As indicated in Figure 6, 20 percent of those who helped provide care outside of the immediate household were children and youth. Care and support occur in a challenging community environment, where 19 percent of households do not have access to clean water and almost a quarter of households were without toilet facilities.

Figure 6: Age distribution of household members providing care and support to seriously ill community members



Conclusion

The findings show that many households' capacity to support and care for OVC is precarious. The extent of poverty in the study area is widespread, and many factors increase households' economic vulnerability, including death, illness, a lack of assets, and households headed by women and elderly people. Extended family networks play an important role in the care of orphans and vulnerable children, but many of these families live in extreme poverty. Government grants make a major contribution to household income, but many households are not taking advantage of government support benefits for which they are eligible. Households affected by serious illness, death, and orphanhood need help from external sources to ensure that the developmental needs of children are met and maintained.

- The study identified the following community needs and potential responses that could be undertaken by NGOs, community-based organizations (CBOs), communities, and government structures. Low household income, savings, and employment levels highlight a need for income-generating activities and community-based savings and livelihood solutions.

- ❑ CBOs can network with local government and put in place referral systems that facilitate application for government grants by needy households and efficient follow-up to shorten the turnaround period.
- ❑ Low levels of schooling among household heads should be given consideration in designing community programs and printing community education and awareness materials.
- ❑ There is a need for community outreach to encourage vaccinations and adherence to immunization regimens.
- ❑ The potential for religious groups and burial societies to provide entry points for mobilizing community members to become involved in the care and support of OVC and seriously ill people should be examined.
- ❑ Gender issues should be integrated into interventions by encouraging male involvement in care and support, and in family life. This would facilitate the construction of positive role models and encourage communities to promote more equitable gender norms.

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¹ “Goelama” is a Tswana term for nurturing and caring.

² Household poverty line is R800/US\$109 per month.

³ Existing access to grants refers to households with eligible members who were already receiving monthly grants at the time of the survey.

⁴ New applications to grants refer to households with eligible members who reported that they had applied for a grant, but were not in receipt of monthly government transfers at the time of the survey.

⁵ Refers to indigenous community savings and income generating schemes that were commonly utilized during the apartheid era for black economic empowerment.

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