A situational analysis of child-headed households in South Africa

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The aftermath of the HIV and AIDS pandemic has resulted in great suffering in terms of loss of income, poor quality of life, morbidity and mortality, with children being destitute and orphaned at an alarming rapid rate. Families and communities are currently unable to cope with the effects of HIV and AIDS with special emphasis on the care and support of the affected orphans and vulnerable children, who as a result have been compelled to look after themselves giving rise to a new type of family, the child-headed household. The emergence of this type of family requires government's response in terms of care and support.

The purpose of this study was to provide a broad picture of the location, prevalence, composition, functions, needs and challenges of child-headed households in South Africa, and explore available and required services, resources and safety nets for children in child-headed households. An exploratory and descriptive design was used for the purpose. The sample consisted of children heading households and those living in the households that are headed by children; government departments responsible for child welfare, such as, the Departments of Social Development, Health, Education and Agriculture; non-profit organisations and communities where these households are predominant.

From the data collected, it was found that the rights of the affected children were compromised. Those heading the households were often not at school and were responsible for domestic chores. The households needed food, clothes, money, shelter, and education. Government in attempting to address these needs required clear policies which will provide a distinction between orphaned and vulnerable children and child-headed households.

The study recommended a collaborative approach as it was shown that there was no single model of best practice to appropriately and effectively address the needs of child-headed households.

Introduction

The increasing morbidity and mortality rates among adults as a result of the many complex challenges including the HIV and AIDS pandemic, other acute emergent infections such as multi-drug resistant TB, poverty, violence, crime, motor vehicle accidents and social maladies of migrant work have resulted in a growing number of orphans and vulnerable children (OVC) (India HIV/AIDS Alliance 2006:2; Tsegaye 2007:4; UNAIDS 2008:12, 20). The rapid rates at which orphanhood and destitution are occurring make it difficult for families and communities to respond in the traditional manner of taking these children into extended families. According to Ayieko (1997:1) and Tsegaye (2007:2), the situation has resulted in the emergence of a new form of family structure; a household headed by one of the affected children now called 'a child-headed household' (CHH).

The phenomenon of child-headed households is complex and multi-faceted. It impacts on the societal framework and has profound implications on the well being of children and the realisation of their rights. It disrupts family and community functioning and negatively affects the rearing and development of children (Motihar 2007:2).

The study on *A situational analysis of child-headed households in South Africa* was commissioned by the Department of Social Development from the realisation that the multi-facetted phenomenon of child-headed households was perceived to be growing in both numbers and complexity.

Background to the study

Despite the preventive strategies implemented via the HIV/AIDS and STD Strategic Plan for South Africa 2000-2005 (Department of Health 2000:1) and the Comprehensive Prevention, Treatment, Care and Support Plan to prevent HIV-transmission, the national prevalence rates continue to rise (Department of Health 2005:1). According to Dorrington, Johnson, Bradshaw and Daniel (2006:3, 8), more than five million people were reported to be living with HIV in South Africa. Of these, more than half were women with prevalence rates ranging between 35% and 46%

among non pregnant women in Kwa-Zulu Natal Province. Despite the increase in the provision of antiretroviral therapy (ART) increasing numbers of people with AIDS are dying with devastating social and economic consequences especially on children (UNAIDS 2006:10; India HIV/AIDS Alliance 2006:4). Of prime concern are children who are orphaned by this epidemic, some of whom are HIV infected. The impact of HIV and AIDS is not only a burden of disease but also a burden on the systems and services that provide support to the affected children and families. The trend is that AIDS orphans tend to be quite young and parents are lost in quick succession of each other (Ayieko 1997:1; UNAIDS 2006:12). The burden of care for these orphaned children is often left to caregivers in the community as members of the extended family or neighbours, who are themselves devoid of human and financial resources, may be overwhelmed by poverty as well as the large numbers and the rapid rate at which children are orphaned. Often children may be left destitute and on their own, hence the child-headed households (India HIV/AIDS Alliance 2006:2).

Description of a child-headed household

A child-headed household has been described within the context of a change in composition, structure and function of a family. According to Germann (2005:149-158), a child-headed household is a household where both parents or alternate adult caregiver/s is/are permanently absent and the person responsible for the day-to-day management of the entire household is less than 20 years of age. Bequele (2007:1) describes a child-headed household as a household where practically everyone who lives in the household is 18 years or younger and the head of the household is one of these children who is responsible for providing leadership and sustenance for the household.

For the purposes of this study a comprehensive scenario (based on the circumstances in South Africa) of a child-headed household was defined and presented by the Department of Social Development as a household where

one of the children or the youth in the house has assumed the principal responsibility for the household inhabitants because:

- a parent/s or primary caregiver/s was/were permanently or temporarily absent as a result of death, employment a way from home (migratory work), abandonment or rejection of the children

- a parent/s or primary caregiver was/were present but abusing alcohol and/or drugs excessively, too ill, terminally ill or too old to provide the care required

Problem statement

The increasing morbidity and mortality rates amongst adults, especially as a result of HIV and AIDS, present a threat to the economic and psychosocial wellbeing of many children worldwide. According to UNAIDS (2008:21), the magnitude of orphanhood and child-headed households is considerable and it is escalating. In a survey conducted in 2002, it was found that 1.5% of households in South Africa were headed by children aged 12-18 years of age (Tsegaye 2007:10). Presently there are over a million orphans in South Africa and 49% of these are as a result of AIDS (UNAIDS 2008:21).

Traditionally, children whose parents had died, were sick or working away from home, would be absorbed into the extended family system. However, recently, the number of orphans and/or vulnerable children has increased to the extent that the extended family's capacity to care for these children is overstretched (Tsegaye 2007:5). The increasing mortality among young adults has also drained society of economically active members. Recent literature reports children without adult caregivers preferring to stay in their homes as a unit rather than being dispersed among relatives or foster care homes (Chilangwa 2004:7; Tsegaye 2007:6). All the above result into child-headed households, a phenomenon that compromises children's rights and development. Interventions that enable communities and government to best support the affected families are also limited.

The study explored the prevalence, lo-

cation, composition, needs and challenges of child-headed households in South Africa as well as the availability of services and resources to address issues related to child-headed households.

Significance of the study

The study was commissioned by the Department of Social Development to provide information that would direct evidence-based policy/pertinent to child-headed households. In addition it was envisaged that the inclusion of the youth who in many cases may have started looking after households at an early age when their parents were ill, especially with AIDS, and subsequently succumbing to the disease, would better highlight the plight of these households.

Purpose of the study

The purpose of the study was to provide a broad picture of the location, prevalence, needs and challenges of child-headed households in South Africa, and explore available and required services, resources and safety nets for children in child-headed households so that gaps can be identified and addressed through government policy. Therefore the objectives of the study were to:

- Explore the prevalence, location, structure and composition of child-headed households in South Africa.
- Identify and describe the needs and constraints of child-headed households.
- Explore the availability, accessibility and effectiveness of community resources and support programmes for child-headed households.
- Provide a report that will assist in policy development in addressing issues related to child-headed household.

The research questions that were addressed inluded:

- What is the prevalence, location, structure and composition of childheaded households in South Africa.
- What are the needs and constraints of these households.
- What is the availability, acces-

sibility and effectiveness of community resources and support programmes for the child-headed households.

Research design and methodology

An exploratory and descriptive design was used to provide information on the prevalence, location, structure, composition, needs and challenges of child-headed households in South Africa as well as available programmes, services and existing gaps in the available services and programmes.

Population of the study

Three populations were used to source the information that was required.

- The first population was that of child-headed households in the nine provinces in South Africa. This population would provide first hand information about child-headed households' needs and challenges thereof.
- The second population was the formal structures in the form of government departments and non-profit organisations (NPOs) that provide support and services to child-headed households. The government departments of choice were the departments of Social Development, Education, Health and Agriculture.
- The third population was community members who provided support to child-headed households in the communities where these children live. In the study the community was referred to as non-formal support structures. It could be individuals such as volunteers, community leaders, educators, ministers of religion/clergy, family members, neighbours, friends and others assisting in the care of these children or these could attend to the needs of child-headed households as a group.

Sample and sampling technique

A multi-staged sampling technique was used to address the various study populations.

Sampling of the child-headed households

First a sampling frame that consisted of all the households in South Africa was used to select child-headed households to participate in the study. This was done by area sampling, whereupon the sampling frame was populated by means of the 2001 census community profile. Based on the population distribution of each magisterial district, areas were identified as rural, urban formal and urban informal areas. Using the Monte Carlo sampling technique rural, urban formal and urban informal areas from each of the nine provinces, totaling 27 areas (see table 1), were selected for inclusion in the sample. This was followed by the sampling of the actual child-headed households using purposive sampling technique. To this effect, a total of 40 child-headed households were selected in each of the 27 areas shown in table 1. In conducting the study, this sample was doubled because in each household, the child heading the household was interviewed as well as one of the children or person living in that household, provided the head child and/or the child or person concerned did not object to the process.

Sampling of formal structures

Formal structures were purposively sampled and clustered in terms of:

(a) Government departments directly working with child-headed households. These were the Departments of Social Development, Education, Health and Agriculture at both national and provincial level. Government officials, managers or HIV and AIDS programme co-ordinators in the four departments at national level and in the nine provinces were purposively selected to provide the information about the services rendered to children in child-headed households

(b) Three NPO's that are funded by government were selected in each province in line with the three areas ie rural, urban formal and urban informal areas (see table 1).

NPO's managers were purposively selected to respond to questions relating to child-headed households prevalence, location, structure, composition, needs and constraints. The criteria for inclusion were that the selected NPO

should:

- be in the sampled magisterial area, ie, rural, urban formal or urban informal
- provide services and programmes for child-headed households
- respond to a questionnaire about its activities in relation to child-headed households
- have in its records or know at least 40 child-headed households from whom data could be collected in its area of operation
- be in a position to identify and release at least ten caregivers to be trained on data collection and to collect data during the investigation period
- ensure return of completed questionnaires to the researcher
- be able to assemble at least eight to ten community members for the focus group discussion on issues of child-headed households in the area, be it rural, urban formal or urban informal.

Sampling of non-formal structures

Convenience sampling of non-formal structures was done where at least eight to ten community members were assembled with the help of NPO, to form focus groups to conduct discussions on issues related to child-headed households. The focus groups could be composed of community members, ministers of religion, teachers, anyone older than 20 years of age, even orphaned and vulnerable youths who were in child-headed households or not could participate.

Data collection

At the level of data collection, the multi-dimensionality and sensitivity of the phenomenon necessitated triangulation of data collection methods. Permission to use an audio tape recorder was sought from all participants before data collection could commence. Qualitative data were collected through personal interviews with government officials/managers/HIV and AIDS programme coordinators, NPO managers, children heading households and those living in the households as well as conducting focus group discussions

with community members. Quantitative data were collected using a questionnaire especially for the child-headed household entity in relation to demographics, socio-economic status and observations made on the environment in relation to the number of rooms in the homestead, safe water provision and sanitation. Provision was also made to assist those children who may find it difficult to express themselves to use pictures or make drawings of what they needed to put across. Field notes were compiled to support both quantitative and qualitative data. Records kept by government officials and non-governmental organisation managers were reviewed to support information in the interviews. After they were trained, caregivers from the organisations conducted interviews at the children's homes because they were well known to the children as they were responsible for home visits in their daily activities and were knowledgeable about the community. The children were therefore comfortable talking to them. This process was monitored daily by researchers who were in the organisations throughout the data collection period. Interviews with government officials and NPO managers were conducted by researchers. The instruments were pre-tested in three provinces. For the rural area, Limpopo Province was used, for urban informal KwaZulu Natal province was selected and for urban formal the Northern Cape province was used.

Data analysis

For qualitative data, analysis was done simultaneously with data collection. Tapes were transcribed, read and re-read and organised according to particular themes and assigned initial codes. Following this, all data was assembled into categories under common themes supported by meaning units and analysed. Quantitative data was cleaned and coded before items in the questionnaire could be captured into the SPSS files for analysis.

Measures to ensure trustworthiness

A research study is trustworthy when it reflects the reality and ideas of participants. Trustworthiness refers to the quality value of the final results and

conclusions reached in a research study. According to Lincoln and Guba (1985:22) trustworthiness is composed of four main aspects, credibility, transferability, dependability and confirmability.

Credibility refers to the authenticity of data collected. To achieve credibility, triangulation was used to collect data. Individual interviews with government officials, NPO managers and children heading households and those living in the household were conducted. Focus group discussions were also conducted. Records in government and NPO offices were reviewed. Observations and extensive field notes were made during data collection. During data analysis researchers engaged with the data during transcriptions and the reading and rereading of these. Before finalising the report, the findings were presented to participants for validation.

Transferability is the ability of the findings to apply to similar situations. Transferability is achieved through detailed descriptions of collected data during analysis. In this study the purposive sampling used to select participants maximised the range of information collected. The documented research methods provided an audit trail for application in other situations.

Dependability refers to the stability of data making it more reliable. In this study data collection was monitored and recorded correctly to yield similar results at all times.

Confirmability refers to the extent to which the results can be confirmed by others in relation to the data collected. To ensure confirmability, the researchers in data analysis kept referring to the interview scripts, field notes and records to align findings with data at all times.

Ethical considerations

Permission to conduct the study was sought and obtained from all the participating government departments and officials, non-profit organisations and their managers and individuals who were to form the focus groups. Informed consent forms were signed or verbal agreements to participate made after the purpose of the study was explained to participants. A special consent/ascent form for the participating children was

designed and only used after its approval by the reference team of the Department of Social Development. Utmost respect of participants was maintained and participation was voluntary and as such, participants were free to decline or withdraw their participation at any time if they so wished.

Findings of the study

The findings are presented according to the samples interviewed.

Formal structures

National government departments of Social Development, Health, Education and Agriculture

The general finding was that departments had policies that addressed the issues related to orphaned and vulnerable children. The policies were not specific to 'child-headed households' as a target. The three departments ie Social Development, Health and Education were playing a critical role in addressing issues of orphaned and vulnerable children. These departments complemented one another in this regard. The Department of Agriculture addressed food security in general and not specifically for child-headed households or orphaned and vulnerable children. The Department of Education was focused at ensuring that learning takes place in the schools by making schools centres of care and support (SCCS). There was a great awareness of the emerging child-headed household type of family and that this type of family was impacting negatively on government efforts on poverty reduction. At national level policies that were available were enabling provinces to draw up plans that would ensure that the children's rights, especially to education, health, safety, and food were realised.

Provincial government Departments of Social Development, Health, Education and Agriculture

In the provinces, the Departments of Social Development were found to be fully active in addressing the issues of welfare in general and that of children in particular. The other departments regarded child welfare services as the responsibility of the Department of Social Development. The roles of the departments of Health, Education and Agriculture were viewed as supportive to the Department of Social Devel-

opment and as such the issue of child-headed households as a focus was not so prominent in their activities. The services and programmes of all the departments were more for children in general and OVC in particular in accordance with the legal stipulation in the Children's Act, (No 38 of 2005) (Republic of South Africa, 2005). The youth, that is, those above 18 years of age even though included in this study, were not in their scope of service coverage.

The Department of Education had programmes that supported early childhood development (ECD), including mechanisms of identifying children in need. To this effect some provinces, such as KwaZulu Natal, had designed a registration form that would assist in the identification of children in need early. The form was issued to *all* learners to complete, so that labelling of those in need of help is avoided. The Department of Health offered free health care services on referral. Drop-in centres ie, places where needy children come to after school for food and assistance with homework, were also another combined initiative of the departments.

Issues needing attention included funding for the caregivers that was different in the Departments of Social Development, Health and Education and the co-ordination of services rendered by the caregivers from the three departments. The Department of Social Development and Education provided a stipend of R500 per month to the caregivers while the department of Health provided a R1000 for caregivers to drive their programme on home-community-based care (HCBC). This caused tension among caregivers. There also was no co-ordination on the distribution of services offered by the various caregivers funded by the departments, and, quite often services from the departments of Health and Social Development were duplicated.

The Department of Agriculture addressed issues of food security in the communities. It provided support for food gardens and the national school nutrition programme (NSNP).

The departments provided support to NPOs that worked with orphaned and

vulnerable children and not child-headed households in particular.

Non-Profit Organisations

A total of twenty seven (27) NPOs were contacted in accordance with the sampled areas, and out of these twenty three (23) were able to participate in the fieldwork to collect data from child-headed households based on the criteria stated before. A total of 230 fieldworkers were trained.

The NPOs were providing a service on behalf of government department and as a result some were funded by government.

NPOs accordingly, understood a child-headed household to be a household headed by someone 18 years or younger in line with child legislation. Some even after the presentation to include youths could not see themselves fulfilling their mandate with the inclusion of the youth, hence the participation of only 23 NPOs. Similar to the provincial departments, NPOs did not have policies specific to child-headed households; policies were for orphaned and vulnerable children and children in child-headed households were categorized as orphans or vulnerable or both.

Non-profit organisation managers found that the child-headed household phenomenon was mainly as a result of HIV and AIDS in terms of morbidity and mortality, then grandparents who had become old and senile and advanced alcohol and drug abuse making the children orphaned and/or vulnerable, in that order of priority. This notion was supported by Dorrington et al (2006:8); Germann (2006:149-150); Ayieko (1997:1); Leatham (2005:15) and many other researchers. NPOs did not regard migratory labour as an issue as they felt that in this instance, the parents are present, they are able to communicate with the children, they provide material and emotional support when necessary.

The NPOs were implementing all the programmes agreed upon with government, such as home-community-based care, voluntary counselling and training (VCT) for HIV and AIDS prevention and control, prevention of mother to child transmission (PMTCT), drop-in centres, national school nutrition

programme (NSNP), early child-hood education and development, adult basic education and training (ABET), lay counselling and peer training and life skills.

The problems organisations had with the management of these programmes were related to funding and management skills which were often poor or non-existent. Organisations reported that funds were often delayed and/or inadequate for their needs.

Non formal structures
Focus groups
Focus groups were held with various community groups. The issue of HIV and AIDS related stigma was indicated as a deterrent to offering assistance. Although in many instance, the parents would have died without disclosing their status, people in the community generally made their own diagnosis. What was also mentioned was that the children whose parents died after a long illness would invariably be left extremely poor with the money spent on medication and hospitalisation of parents. Household effects would also be in disrepair. Ward counsellors in most areas were, according to the focus groups, not helpful in addressing the needs of these children. Communities felt that there was no involvement and commitment from political structures in addressing the care and support of these children.

In the issue of HIV infections, people cited cultural practices that were encouraging the spread of HIV, especially those cultures where it was acceptable for men to have more than one partner or wife.

Child-headed households
In this study a total of 1528 individual interviews were conducted in 797 child-headed households. The reasons for children heading households was reported as death of one (40.3%) or both (43.3%) parents mainly as a result of HIV and AIDS. A total of 66.1% were females while 31.9% were males. Tsegaye (2007:7) tends to support this trend when he reports that the presence of an adolescent girl in the household with no adult caregiver tends to trigger the establishment of a child-headed household. The average occu-

Table 1: Sampled areas representative of provinces in South Africa

PROVINCE	RURAL AREA	URBAN FORMAL	URBAN INFORMAL
Eastern Cape	Nyosini	Molteno	Uitenhage
Free State	Thaba NChu	Bethlehem	Qwa-qwa
Gauteng	Vereeniging	Springs	Soshanguve
Kwa-Zulu Natal	Msinga	Port Shepstone	Chatsworth
Limpopo	Giyane	Nebo	Waterberg
Mpumalanga	Lydenburg	Nelspruit	Witbank
Northern Cape	Barkly West	Kimberley	Gordonia
North West	Taung	Mafikeng	Maboloka
Western Cape	Paarl	George	khayelitsha

pancy although five (5), could be seventeen (17). Most families included an own child, especially where the head child was a female. This finding was supported by literature as reported by Luzze (2002:1-2) and Leatham (2005:15) who also placed emphasis on high pregnancy rate, role relations and division of labour in these households. In line with the concern and presentation of the Department of Social Development, only 47.9% of those interviewed were under the age of 20. A total of 52.1% were aged between 20-34 years of age (these were categorized as youth) and of these youth, only 8.5% were employed. A total of 57.7% received a social grant, distributed as child support (61.8%), disability (5.0%) and foster care (33.2%). Education was compromised with 46.4% of those interviewed not attending school. These cited 'lack of money' to pay for their education as reason for non-attendance of school. Only 12.9% had completed grade twelve and 11.5% were currently in grade twelve.

The children heading the households had a responsibility of providing food, clothes, shelter, education and looking after the sick inhabitants of the households. For the 91.5% that did not have a source of income these could only be met by accepting donations or using the child support grant. The the head childen reported cleaning the house, washing clothes, preparing meals and helping siblings with homework. These responsibilities interfered with the child's schooling and often the head

Table 2: Urgent needs as identified by the children

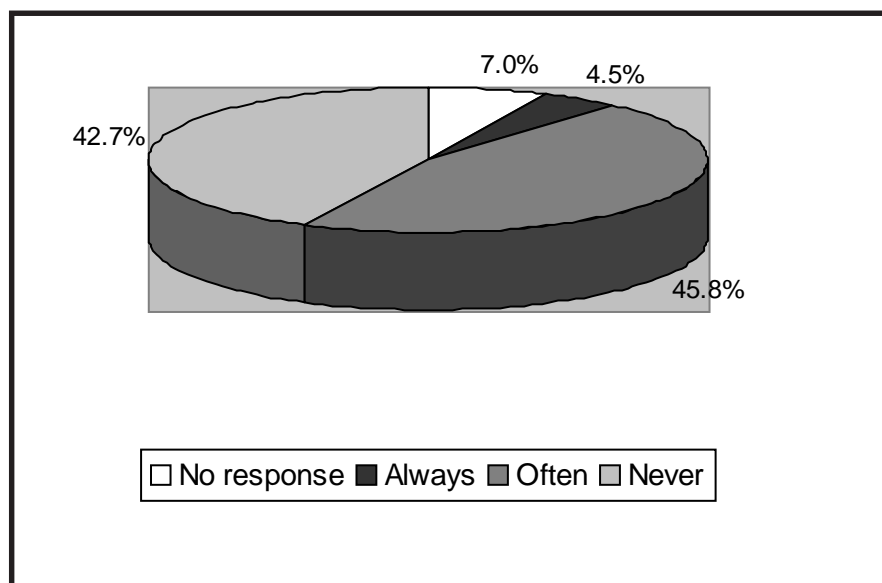| Needs	N=%
Food	57.6
Clothes	54.8
Money	38.1
Shelter/housing	30.6
Education	17.3

child was the first to drop out of school.

In child-headed households food and clothes were used as indicators for the level of need. In this study 33.1% of the households had two meals per day and 42.0% had three meals. This was very emotive as evidenced by the response to the question 'How often do you go to bed hungry? In figure 1.

When asked about preferred needs in terms of clothing and blankets, 79.5% indicated that they needed clothes to wear while 57.8% needed blankets to keep warm at night.
During the investigation it was also found that 61.1% of the children were left in dwellings which they considered to be their physical homes even though there were no title deeds to this effect. A total of 36.9% lived in shacks, 47.5% had three or less rooms with most (66.5%) sharing bedrooms. The children also reported feeling unsafe (34.3%) in their homes.

Figure 1 Frequency of going to bed hungry

The children summarised their urgent needs as food, clothes, money, shelter and education (see table 2).

Irrespective of the suffering incurred, the children preferred being together, suffering as a unit. This supported the finding by Ayieko (1997:2) and Chilangwa (2004:9) with regard to decisions made about child placement after parents die.

Discussion of findings
Prevalence, structure and composition of child-headed households

From the findings in the qualitative and quantitative data, child-headed households were prevalent in rural and urban informal areas in South Africa. This finding was in line with that of Hess (2002) and Luzze (2002:1) when they reported on the issues of disease, morbidity, mortality and housing in rural and urban informal areas. The youth headed households were in the majority. The households lacked information with respect to accessing services as evidenced by the few (57.7%) receiving child support grant. Many (66.1%) households were headed by females as is the norm where this phenomenon exists. The prominent presence of own child in the composition of the households was indicative of high pregnancy rates in these households. This also provides information in relation to the use of child support grants to support households where there are no

sources for funds. The issue of youths (as opposed to children) heading households as indicated by the Department of Social Development was proved to be correct as 52.1% of the interviewed child-headed households were actually headed by youths aged 20-34 years of age.

Needs and constraints of child-headed households

The socio-economic needs were listed as nutrition, health, hygiene, education, safety and shelter in terms of housing and clothing. Most of those interviewed did not have a source of income. This exposed the children to sexual exploitation and involvement in unbecoming behaviour such as pick-pocketing and gangsterism as explained by Loening-Voysey and Wilson (2001:2) and Germann (2006:149-158). Psychosocial needs such as counselling following multiple losses including parental deaths and dispersal of siblings were mentioned and from the findings these were not met at all, hence the difficult behaviours displayed by these children. Parental responsibilities and poverty were constraints that often led to early school drop-out, pregnancy, exploitation, negative behaviour, sexual abuse and stigma.

Availability, accessibility and effectiveness of community resources and support programmes for child-headed

households

The interviewed government departments provided support programmes such as those in the drop-in centres, the national school nutrition programme, voluntary counselling and training for HIV and AIDS prevention and control, prevention of mother to child transmission of HIV infection, early childhood development, home community-based care, schools as centres of care and support, child care forums and income generating programmes geared towards poverty alleviation, through NPOs. There were problems in accessing services from these programmes as some of the children in the affected households did not have the information on how to access services, while others lacked correct documentation such as identification documents and birth certificates. Foreign nationals, especially those in the rural areas and informal settlements who were without correct documentation were mostly affected as they could not apply for grants.

The implementation of national policies also presented a problem. For example, there were schools that excluded children based on their inability to pay school fees irrespective of the 'no school fees' policy for designated schools and children.

Often funding was either not adequate, delayed or in some instances absent to support participating organisations. This had a negative impact on the service delivery by NPOs.

There was a shortage of social workers, a huge caseload, burnout and poor support to NPOs in the execution of their duties. Ineffective monitoring, evaluation and information management resulted in poor planning that impacted negatively on service delivery.

Recommendations

As the purpose of the study was to provide information about the seriousness of the child-headed household phenomenon to inform policy development, the first recommendation was for the departments at national level to develop guidelines for the management of child-headed households within the existing policy framework for orphaned

and vulnerable children. The guidelines would provide operational terms that outline the intensity and complexity of issues impacting on children heading and living in child-headed households and how these can be addressed. Article 137 of the Children's Amendment Bill (Republic of South Africa, 2006) would need to be revisited to offer a clear directive if the youth is to be included in the presentation of the emerging family structure.

The policy on social grants has to be based on need rather than age and the termination of the grant has to be phased in rather than abruptly to allow for the necessary adjustment.

Provinces should interrogate and monitor implementation of existing policies that address child-headed households issues. For example policies related to the South African Schools Act (1996) as amended by the Education Laws Amendment Act (No. 31 of 2007) (Republic of South Africa, 2007) make provision for no fee schools and compulsory education for South African children aged 7-14, yet in the study 46.4% of the children were not at school , reportedly due to lack of money to pay fees.

There was also a need to streamline programmes and co-ordinate the functioning of organisations in service provision to avoid duplication thereof. The provinces are to do an impact analysis of existing programmes to assess effectiveness and where possible prioritisation of programmes in areas of operation.

Conclusion

The study has highlighted the magnitude of the phenomenon of child-headed households. The psycho-socio-economic needs are complex and are rooted in poverty that is pronounced in these households. Failure to address the psychological needs has enhanced the negative labelling of these children based on their anti-social behaviour. The study has also shown that there is no single model of best practice to appropriately and effectively address the needs of child-headed households. Management of the issues identified calls for government, community and families to work together in a strategic manner.

Acknowledgements

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