bulungulaincubator

Xhora Mouth Administrative Area

Household Profiling Survey & Way Forward

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1. Organisational Background

The Bulungula Incubator was formally constituted in 2007 although the work of the founding members of the organisation began in the area in 2002. The organisation is based on the Wild Coast of the Eastern Cape in a remote area of the former Transkei 'homeland'. Development in the homelands, especially of the rural areas, was practically non-existent during Apartheid. Little has changed post democracy, and still today basic government services such as roads, clean water and healthcare do not reach many villages. Formal education has always been, and remains largely extremely weak. Our work in the area began with the establishment of the environmentally sustainable, community owned Bulungula Lodge and expanded into the four development areas of the Bulungula Incubator, namely Education, Health and Nutrition, Sustainable Livelihoods and Basic Services.

The organisation was launched in response to the lack of government services in the area. Community development, social inclusion and cohesion and human rights awareness have become an integral part of our work. We strive to create an environment that builds cohesion with government departments and facilitates state involvement in the community where relevant and necessary. Our mission is to achieve our vision of the creation of vibrant and sustainable rural communities by partnering with our community, government, NGO's and other innovative thinkers to find synergies between the traditional rural African lifestyle and culture, and external technologies and innovations. These synergies must always seek to enhance the positive aspects of traditional rural life and/or mitigate the problematic aspects. They must be in accordance with our values and must recognise the fundamental human rights enshrined in our constitution. The Bulungula Incubator further aims to be an influential agent for change by spreading our vision widely and working to inform government and corporate policy.

The Xhora Mouth Administrative Area, in which we work, is made up of four villages: Nqileni, Folokwe, Mgojweni and Tshezi located in a remote part of the Mbhashe Municipality. These four villages have a population of about 4000 people; the StatsSA community survey estimated the Mbashe municipality to have a population of 262 008. This is the poorest municipality of the Amathole District. 96% of households in this municipality have an income of less than R1600/month and 78% of the population is below the poverty line (an increase of 10% in a decade). 75% of the Mbhashe population have no access to clean drinking water and 74% of the population have no access to any kind of toilet at all. 72% of the population use firewood for cooking and 79% live in self-built mud brick houses. Our offices are located

in Nqileni village, the most remote of the four villages in which we work. Just over half (53.8%) of households have had at least one child die and a third of those have lost more than one child, mostly due to diarrhoea, probably caused by the lack of clean water and sanitation. The Bulungula Incubator was launched in response to this dire situation.

2. Household Profiling Survey

Since the launch of the BI in 2007, there has been significant expansion in the reach and scope of our programmes. It was our sense that a survey of household demographics and impact indicators of our work would inform our future plans and strategies.

With the help of a Canadian volunteer, Kate Rice, a Social Science researcher specialising in anthropology and a PHD candidate at the University of Toronto, we launched a Household Profiling Survey project that included demographic information, health, child mortality and statistics on household nutrition; qualitative questions explored themes of individual aspirations, concerns and outlook for the future, views about traditional and political structures and experiences with the public health system, accessing employment and schooling. This was the proposal that the DG Murray Trust supported us with earlier this year.

While conducting the survey, Kate trained Nomzingisi Hopisi, our Health Programme Manager and a local community member, to conduct the surveys.

The results of the survey were fascinating and have guided us in the development of our plans in Education, Health and Social Development projects.

2.1 Narrative summary of the results of the survey

The survey was conducted in four villages (Nqileni, Tshezi, Folokwhe and Mgojweni) in the Xhora Mouth Administrative area of the Eastern Cape, the in which the BI conducts its development work. The data collection was undertaken between June 2011 and May 2012 and analysis of the data was completed by July when it was presented to our Board for informing our strategic and programmatic plans.

The objectives of the research were exploratory; rather than approaching this study with a research question in mind, we were hoping to get a fuller picture of the material and social circumstances of people's lives in the area. We also strove to provide a forum for all local families to share their experiences, and to express their opinions and concerns on issues such as local leadership and governance, health care, and hopes and goals for the future of

their communities. Thus, this report is primarily descriptive in nature, providing a baseline for future research and analysis.

The research was guided by an in-depth interview questionnaire which included both quantitative and qualitative questions. We aimed to speak with an adult representative from each household in each of the four villages, although all participants were assured that their participation in the study was entirely voluntary. No one declined to participate, although several individuals declined to answer certain questions. Once collected, the data itself was analysed by both a qualitative and a quantitative researcher.

Challenges and Limitations of the Data

Although the survey questions were designed by a university educated researcher, the surveys themselves and the inputting of the data sheets was done by local community members. Reading, writing and computer skills are severely limited in the area and while quality control checks were conducted it is possible that the quality of some datasets were compromised. In these instances, the data were excluded. The process has taught us many lessons about conducting future surveys. What we have achieved is a sense of the most pressing issues affecting community members, some guidance for our future programmes and plans and a baseline of data on which to build in future.

Demographics & Employment

As mentioned above, this research was carried out in four rural villages. These villages are in close proximity to one another, and many individuals and families in one village are related by blood, marriage or clan affiliation to individuals and families in one of the other villages. By our count, the largest village by population comprises 864 people, and the smallest 666. The average household size across all four villages is 6.5 people.

The majority of marriages are under customary as opposed to civil law, although more and more young, married couples are married under civil as well as customary law. Just under two-thirds of households (62%) have at least one member who is employed. Of this 62% of households, 42% have only one employed family-member. Broken down by village, however, it is evident that the presence of the BI and Bulungula Lodge have a significant impact on this statistic. While 72.4% of households in Nqileni, where the Bulungula Lodge and Incubator are based, have at least one employed member, only 50% of households in Tshezi, 58.6% in Mgojweni and 66% of households in Folokwe have at least one employed family-member. When the Bulungula Lodge first opened in 2004, there was no other employment in the area

and little informal activity except for a few spaza shops and shebeens. The Bulungula Lodge now provides an income for half the households of Nqileni Village and the Bulungula Incubator for just under 200 people in all four villages. Of those who are employed, 24.7% are migrant mineworkers in the North West province.

Food Security

In trying to determine nutritional needs we asked the question "how often in the past year have you been without enough food to eat?" We asked people to specify "Sometimes, Often, Never, or Rarely." Across the four villages, only 16.6% of families reported "Never" being short of food, while 15.3% reported "Often" suffering food from food shortages. Almost 39% reported "Sometimes" being without sufficient food, while 27.7% reported "Rarely" suffering in this regard. Data is missing in only 1.8% of households. In summary, more that half of households report often and sometimes being short of food.

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In addition to asking about access to sufficient food, we also asked "how often in the past year have you been without access to a cash income?" We asked people to choose one of the same four responses that were given with regards to food. Overall, 7.6% of households reported "Never" having access to a cash income and 35% of respondents said that they "Sometimes" or "Rarely" were without access to cash.

Loss of Lives of Children

While our survey was not designed to assess an official child mortality rate because that would require professional survey techniques, the data gathered are useful in assessing the extend of the loss of lives of children experienced by households. The quantitative data that we collected on child lives lost is among the most complete of all the data that we collected. Only 1.8% of households did not respond to that question. Based on the responses that we received, ***just over half (53.8%) of households have had at least one child die*.** Mgojweni has the highest percentage of households that had experienced child death (61%), and Folokwhe the lowest (47.1% of households have had at least one child die). Nqileni and Tshezi are both in between, with 49.1 % and 57.4 % respectively. This reflects a very high infant mortality rate.

Broken down further, ***26% of households have had one child die, while 29.5% have had more than one child die*.** The greatest number of child deaths per household was nine, although only one household had had nine children die, and only one had had eight children die. Twelve households had had six children die, however, and several dozen had experienced three child deaths. The vast majority of childhood deaths occur in the first years, if not months-of life. When asked why these children had died, most people attributed these deaths to diarrhea or other gastro-related complaints, probably due to a lack of access to potable water. Overall, child mortality due to diarrhea seems to be declining, although this is difficult to establish from our data.

Another interesting finding relates to the number of child deaths per woman. While a number of women had not had any children die, we found that if a woman had had one child die, she was likely to have had several die. In other words, while roughly half the women had not had any children die, the number of women who had had only one child die was quite low. It was more likely that a woman would have had two or more children die. This reinforces the suggestion that the gastro-related complaints are due to a specific household or area's lack of access to potable water.

With the exception of most households in Nqileni, which recently acquired the means to harvest some rain water, the majority of households do not have any access to a reliable and safe water source. In Nqileni 86.2% of households report having at least one water tank. The water situation is most critical in Mgojweni, where 91% of households report not having a water tank. There are more tanks in Folokwhe and Tshezi, although 82.4% of families in Folokhwe and 77.8 % of families in Tshezi report not having a water tank. Projects for rain water harvesting, boreholes and education about optimal water usage have been an important part of our programmes since our work began in the area. A pilot project, being run in conjunction with the CSIR on the use of the Nazava Water filter has recently been launched in all four villages

The quantitative data provides an interesting starting point to explore hospital versus home-birth practices in the four villages. Overall, 41.6% of households reported that the women in that household give birth at home, while 40% reported giving birth in hospital. A further 9.4% reported either that some women in the family gave birth at home and others in hospital or that the woman and/or women in the family gave birth to some children at hospital and to others at home. Data was only missing from 2.3 % of households overall, with a further 5.9 %

being inapplicable (for instance childless households, or households composed only of men).

The qualitative data is particularly helpful in expanding on the information provided above. Younger women tend to go to hospital, while most older women gave birth at home. A very few women,including one women in her early 30s, gave birth alone, while most women who gave birth at home were assisted by older female in-laws. A few younger women explained that they chose to give birth at hospital based on the instruction of nurses and doctors that they had seen throughout their pregnancy.

Given the distance to hospitals and the lack of access to pre and post-natal care, this is an area we have highlighted for development in our Health Programme and, in particular, our Home Based Care project (see further details in 'Programme Plans' below).

Chronic Health-related issues

Our data indicates that people seek medical care from a number of different clinics and hospitals, which is unsurprising given the closest clinics differ from village to village. Just over 43% of families stated that they seek medical care at Nkanya clinic, including virtually all families in Nqileni. Jalamba clinic was the second most popular place to seek medical care (39.5%), especially for residents of Mgojweni (66% preferred Jalamba). People from Mgojweni also reported going to Madwaleni hospital for medical care (20.7% said that they go to Madwaleni), as well as a significant percentage of people from Tshezi (13%). Likely due to distance factors, relatively few people from Nqileni and Folokwe reported going to Madwaleni for reasons other than to give birth. Overall, 10.5% of households across the four villages reported going to Madwaleni. A small number of people preferred either a clinic in Mpame, or to go to Mthatha.

This year, with the help of the community and support from the government funded Community Work Programme (CWP) we opened a village-based Health Point conveniently located between Mgojweni and Folokwe villages. It is used by the medical staff of Madwaleni Hospital for ARV distribution and as a venue for the mobile clinic. With the community of Nqileni Village we are busy building a second community health point. In the meantime the same services as the at the first clinic are being distributed from a community member's home in the village.

High Blood Pressure

A large number of people in all four villages reporting having high blood pressure. Given the

importance of a healthy diet and exercise for the prevention and management of high blood pressure, we have begun to incorporate this kind of information in our monthly Community Health Day Workshops (see more information on this below).

Epilepsy

A surprising number of people have epilepsy, especially in Nqileni. The causes of epilepsy are various, so this is a difficult issue to address. Apart from ensuring access to clinics for treatment, there is little that can be done about this condition.

HIV/AIDS and TB

All data that we collected was offered voluntarily by respondents in response to questions posed, meaning that the number of families who reporting having and HIV-positive member(s) may not reflect the actual number of households where HIV is present. There are many reasons why many people might withhold that information from the data collectors. That said, what is striking is that many more families in Mgojweni, Tshezi, and Folokhwe were willing to volunteer HIV as either a medical condition that was present in their household, or else as a cause of death of one of their children. In contrast, only one person in all of Nqileni mentioned that someone in their household was HIV-positive and on treatment. It is difficult to speculate as to why people in Nqileni would be less forthcoming about HIV and AIDS in their households. Some people have suggested the relative isolation of Nqileni relative to the other villages may have something to do with it. It is clear that there is room for greater effort to improve the climate of open dialogue and acceptance of HIV, especially in Nqileni. Our ongoing monthly Community Health Workshops that offer voluntary testing and counseling facilities on site, on a rotating basis, in all 4 villages addresses this issue.

It is also noteworthy that many people in all villages reported having TB, or having finished TB treatment. Indeed, it would seem that TB is one of the most serious medical issues in these communities. While not everyone with active TB is also HIV positive, the World Health Organization estimates that the chances of developing TB are at least 20 times greater in HIV-positive people (WHO 2012).

The Home Based Care project has trained caregivers in HIV theory and the practice of caring for people living with HIV and AIDS. Intensive on the job training at a chronic care facility in Mthatha has also contributed to their ability to assist the community members they work with in complying with medication regimes, psychological support, the importance of good nutrition, attending support groups and principles for general health management whilst living

with a chronic disease.

Schooling

The information that we have on schooling is primarily derived from the quantitative data, as few families brought up schooling-related issues in the qualitative portions of the interview questionnaire. It should be noted, however, that there is a lot of missing information in our data-set as far as schooling of children is concerned, especially with regards to Tshezi and Mgojweni villages. This is due, in part, to older family-members being uncertain of whether children were schooling, but is also do to inconsistencies on the part of data-collectors. Information from Nqileni is much more complete in this regard.

Only 31 % of households reported that all school-aged children under age 15 were attending school. Even in Nqileni, where only 12.9% of household have missing data regarding schooling, only 44 % of households reported that all school-aged children were attending school. Just over two-thirds of households in both Mgojweni and Folokhwe reported that all school-aged children were schooling, while only 7.4 % of households in Tshezi were schooling. The large amount of missing data from Tshezi should be taken into consideration here. Regardless, the quantitative data indicates that a high number of children are not schooling. Qualitative data indicates that this is partly because many children drop out of school at an early age:

Thirteen year-old [daughter] dropped out of school in grade four. She said its because she has no school uniform (Nqileni)

Young people are not doing well. They don't want to go to school, so they are not schooling (middle-aged mother, Mgojweni)

After just 2½ years of the delivery of educational excellence at the Jujujrha Education Centre, opened by the BI in 2009 the communities of the other 3 villages in the area, Folokwe, Mgojweni and Tshezi, approached the BI to start preschools in their areas. This clearly demonstrates the a success of the JEC building parent activism for education; the importance of education is growing throughout the area .

The “ECD in the home” project that will be run by our Home Based Care team will build on these successes – further details in the planning section below.

Social Grants

According to the quantitative data that we collected, 72.5% of households receive some income through child support grants. It is noteworthy that 78.4% of families in Nqileni receive

child support grants, 73.5% in Folokhwe, 73.9% in Mgojweni, and only 63.9% in Tshezi. It should be emphasised that it is unlikely that there are more families with children in Nqileni relative to the other villages. Rather, this discrepancy is likely due in part to the work of Bulungula Incubator staff who facilitate between Nqileni residents and government. Most families who receive child support grants receive more than one. Although members of the communities of all four villages are able to request assistance in the application of child grants the location of the BI office in Nqileni Village is prohibitive. Our team of Home Base Care givers will be able to address this issue during their new work plans, more details in the planning section below.

Thirty-nine percent of households receive old age pensions. As would be expected, a lower percentage of families receive disability grants, 7.1% across the four villages.

As an interesting aside, when asked about their fear or worries about the future, quite a few people in Folokwhe said that they feared that the child grants would stop being paid out. One woman, for instance, said that she worries that both child grants and disability grants will be taken away, and that she has heard rumors that this could happen.

Gardening, Animal Husbandry and Agriculture

77% of households across the four villages said that they had a garden. The most popular crop, by far, was mealies. The second most popular crops were pumpkins and beans, both of which were grown by just under 10% of households across the four villages.

While approximately three-quarters of households have gardens, most people are growing a very limited diversity of crops in their gardens. Indeed, only 21.5% of households have gardens in which three or more fruits and/or vegetables are grown. This relative lack of variety in crops is problematic for several reasons. Firstly, a diet heavy on simple carbohydrates is unlikely to provide all the nutrients necessary for healthy living. Moreover, it is risky to rely too heavily on one particular crop. The summer of 2011-2012, for instance, was a bad one for mealies due to a long dry spell in January.

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Three-quarters of households report having livestock, and there is virtual no missing data for this variable. There is considerable variation across villages in terms of livestock ownership. A higher percentage of families in Nqileni (83.6%) have livestock relative to the other villages. Only 67.6% of households in Tshezi report owning livestock, compared with 77% in Folokhwe and 71.2% in Mgojweni.

We collected a great deal of information on number and type of livestock. The following are a few noteworthy findings: the majority of households (62.2%) do not own any cattle. The most cattle owned by any one family is 21, but 95% of households own 8 cows or fewer. Two-thirds of families do not own goats, although those that own goats tend to own several of them. Twenty percent of families own between one and seven goats. The most goats owned by one family is 42, although only 5% of families own more than 13 goats. Pigs are a less popular animal; less than 10% of households own at least one pig. Chickens are the most abundant form of livestock, and are also the most popular. Two-thirds of households report having at least one chicken. Fifty-five percent of households have between one and ten chickens, and 10% of households have more than ten chickens. The most chickens owned by one household is 34. Only 13% of households report owning sheep, but those who own sheep tend to have several. Indeed, no one reported owning only one sheep, and one family report owning an impressive 78 sheep. Ninety-eight percent of households own 20 sheep or fewer. Geese, ducks, mules, donkeys and horses are the least popular livestock. Only 8% of households report owning a mule, and no one owns more than two mules. Five percent of households report owning horses (the most horses owned by one household is four), just over 5% own donkeys (the most donkeys owned by one household is 7) and less than 5% of households own geese.

3. Programme Plans

The results of the survey has shaped the plans for our Health Programme. It currently has 5 main focus areas:

1. Monthly on-site voluntary HIV testing and counseling facilities
2. Community Health workshops: HIV, TB, Hypertension, Diabetes, Health in Pregnancy, Alcoholism
3. Community Health Points
4. Home-based Care
5. Permaculture gardens, nutrition and eradicating intestinal parasites

In addition to these focus areas, the programme will be augmented with:

1. Daily home based care plans tailored to each households' needs
2. Child & Youth Care workers based on the Mentor Mothers and Isibindi Programmes
3. Dedicated gardens for vulnerable community members
4. Taking ECD into the Home
5. Ophthalmic Health

3.1. Programme Plan Details

When the BI was launched in 2007, the Health Programme began with a focus on school nutrition, community permaculture projects and the eradication of intestinal parasites. In 2010 the programme began to grow significantly in size and scope. A dedicated Health Programme Manager enabled us to begin to assist community members with government grant applications and to assist widows and families with accessing mining pension funds - 179 individuals have been assisted in a range of official applications.

Since then the programme has grown significantly.

Monthly on-site voluntary HIV testing and counseling facilities

Because our area is remote with little access to information about sexually transmitted diseases or the means to prevent them, we launched a campaign that gives communities the opportunity to access voluntary HIV-testing facilities, contraceptives and workshops that inform about HIV, health in pregnancy, alcoholism and other important health issues.

Since April 2011, we have been running these campaigns monthly, rotating between the 4 villages of Folokwe, Mgojweni, Nqileni and Tshezi. Hundreds of community members participate in the voluntary HIV testing facilities, attend the workshops and gain access to contraceptives in an area where there are no clinics, pharmacies or shops at which they can be obtained. These health days have become important community gathering events where we cook a hot lunch, erect a tent, play music, screen episodes of HIV and sexual awareness programmes, run informational workshops and are planning to hold sports events to keep young people interested!

Community Health & School-based workshops: HIV, TB, Hypertension, Diabetes, Health in Pregnancy, Alcoholism

In addition to the monthly village-based events, additional health workshops and open days are held at our new Community Health points and for the staff of the Bulungula Incubator and the Bulungula Lodge.

School-based awareness campaigns are run weekly at Xhora Mouth and Noofisi SP schools, with workshops designed specifically for young learners. Topics covered include HIV and AIDS, nutrition, drugs, alcohol, gender roles and life-skills. The programmes are interactive, encourage discussion and participation and use a series of games and audio-visual materials that stimulate and keep young learners interested. About 70-90 learners typically attend the weekly sessions.

Community Health Points

Because we are so remotely located from local clinics and hospitals, the community, assisted by the CWP established a Health Point for ARV distribution and as a venue for HIV counselling and support groups and the mobile clinic van. The site was donated by the community and renovations were completed with the help of the CWP. The medical staff from Madwaleni Hospital run the regular HIV counselling support groups, distribute anti-retroviral medication and provide a bi-weekly mobile clinic, present ad hoc workshops and open days in a range of health services including chronic care and ante and post natal care.

A second health point is being built by the Nqileni community with mud bricks, additional building costs and labour will be sourced from the CWP. While the building is being completed, a temporary clinic is being held at the home of a community member.

All these activities are managed by our Health Programme team, led by Nomzingisi Hopisi.

Home-based Care

In 2011 we launched a Home-based care team of 2 caregivers per village. These caregivers have now been trained in First Aid Training by St. Johns Ambulance, HIV health literacy and working with people living with HIV by Siyayinqoba and have received intensive on the job training in chronic care at the Zingisa Rehabilitation Facility.

We began with a team of 8 caregivers and have now increased that to a total of 24. The additional home based caregivers will focus on the needs of children and youth. This will enable the original team to concentrate on the elderly and chronically ill while the new team members will be receiving training in the principles of the programme run by Philani (Mentor Mothers) and Isibindi (Child & Youth Care Worker programme). We have been exploring these programmes for lessons that can be learned in managing child nutritional and other primary health care needs and the needs of vulnerable youth.

While performing their caregiving services, the home based care team are compiling a needs analysis of each household in the village to assist us in ensuring that we have an appropriated, customised daily care plan for each household.

In addition to health related care, our caregivers will be training with our very competent ECD practitioners on how to take ECD into the home. Here the focus will be on the 0-3 year old group: working with parents on the importance of stimulation for infants by using baby blankets with contrasting colours and patterns and making mobile toys and educational materials from with locally available resources and materials.

Our home based care team have also managed our Eye Clinic project. We were lucky to have Dr. William Mapham visit our area to assess potential patients qualifying for cataract surgery. We then helped these community members to make the long trip to Port Elizabeth for the surgery and the results were life changing! The project has now been given an additional boost with a collaboration with Mercy Ships and Zithulele Hospital where full eye checks are done on site in each village to determine overall ophthalmic health, not just cataract problems and where spectacles can be bought, if needed, at R30 per pair.

Nutrition, Permaculture and the Eradication of Intestinal Parasites

Nutrition through our permaculture gardens has always been a part of our health programme. We began with the gardens at Noofisi Primary and later Jujurha Preschool. With the opening of our new preschools, we will have five school-based gardens and are working on an additional four gardens for each of the villages. The produce from the village-based gardens will be distributed by our home-based care team to homes of the elderly, infirm and vulnerable members of our community who are in need of assistance.

Intestinal parasites and cysticercosis are significant problems for us, being located in a remote rural community where there is no access to municipal piped water and no toilets of any kind. Since the opening of the Jujurha preschool, we have offered a deworming programme to all children, staff and community members twice a year. We hope to be able to extend this to the surrounding communities as parasites are devastatingly injurious to nutrition, health and the ability to perform at learning.

4. Annual Budget for our Health Programme

Description	Item cost	qty	monthly cost	annual cost
Personnel				
Project Manager Salary	R 4,000.00	1	R 4,000.00	R 48,000.00
Community Health Workshops & Voluntary HIV testing				
Workshop Speakers	R 500.00	2	R 1,000.00	R 12,000.00
Tent	R 300.00	1	R 300.00	R 3,600.00
Chairs	R 2.00	50	R 100.00	R 1,200.00
Microphone	R 100.00	1	R 100.00	R 1,200.00
Wood for cooking	R 30.00	1	R 30.00	R 360.00
Catering	R 35.00	100	R 3,500.00	R 42,000.00
Goodie bags with condoms	R 20.00	100	R 2,000.00	R 24,000.00
Preschool Nutrition Project				
Monthly Staples	R 4,000.00	1	R 4,000.00	R 48,000.00
Kitchen consumables	R 3,000.00	1	R 3,000.00	R 36,000.00
Deworming Programme	R 5.00	3000	R 2,500.00	R 30,000.00
Training Caregivers				
Accommodation, stipends	2000	24	R 4,000.00	R 48,000.00
Transport	500	24	R 1,000.00	R 12,000.00
Project Costs				
Admin/Overheads	R 3,000.00	1	R 3,000.00	R 36,000.00
Transport	R 1,000.00	1	R 1,000.00	R 12,000.00
Total Annual Project Costs				**R 354,360.00**

We look forward to continuing our partnership in community development with the DGMT!