CARING AND CONTRIBUTING:

THE ROLE OF OLDER WOMEN IN MULTIGENERATIONAL HOUSEHOLDS

IN THE HIV/AIDS ERA

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ABSTRACT

This paper explores the coping strategies of households in rural South Africa, where HIV/AIDS morbidity and mortality are having profound effects on household resources. The paper focuses specifically on the potentially crucial role older women's pensions play in multi-generational households both during crises (e.g. HIV/AIDS morbidity and mortality) and for day-to-day subsistence. We conducted semi-structured interviews with 60 women between the ages of 60-75. Half of the respondents are South African born, and thus eligible for the South African non-contributory pension; the other half are self-settled Mozambican refugees, who officially were not eligible for the pension until recently. The qualitative fieldwork took place in the Agincourt Health and Demographic Surveillance System fieldsite, which provides access to rich annual longitudinal quantitative data on all area households. By combining the data sources, the project produces a rich picture of the importance of older women and their pensions to households.

INTRODUCTION

As HIV/AIDS has attained epidemic proportions in sub-Saharan Africa over the past 10 years, it has reached particularly high prevalence rates in southern Africa. It is not just the epidemic proportions that make HIV/AIDS different from other diseases, however. The age and gender structure and long duration of the illness, as well as the stigma attached to it, make the effects of HIV/AIDS on individuals, families and communities much different than other diseases common in Africa. HIV/AIDS largely strikes prime-age adults and, in higher HIV/AIDS areas, more women than men. The disease almost always entails a protracted period of morbidity and extensive illness before death.

For women over the age of 60, the primary experience of HIV/AIDS is through their interactions with kin who are at risk and who are sick, rather than through their own risk or sickness. Thus, older women are much more likely to be *affected by* rather than *infected with* HIV/AIDS. They are often the primary caretakers of the sick, of the children of the sick and of the orphaned. They and their households must cope with loss of income those sick or lost to AIDS previously provided. In addition to the emotional and physical aspects of caregiving, they often have new financial commitments. For example, relatives of individuals living with HIV/AIDS may help pay for allopathic and traditional medical treatments, transportation and school fees for grandchildren, as well as subsistence needs of the household. The financial burdens of HIV/AIDS-related morbidity are further compounded when a death occurs, resulting in substantial funeral-related expenditures. Financial responsibilities may also arise due to non-HIV/AIDS related crises like children's unemployment, gaps in remittances from migrants, and caring for grandchildren of non-married parents. In the South African context, the national means-tested non-contributory pension program may lead to an even greater reliance on the elderly for financial assistance.

All poor South African female citizens over the age of 60 and male citizens over the age of 65 are eligible to receive a monthly government pension, which in 2004, was SAR 740 (approximately 100USD). Until recently, Mozambicans living in South Africa were not legally eligible to receive social grants. In addition, there were, and still remain, some local and financial impediments to Mozambicans obtaining the necessary documentation to access social grants. In this rural area, with high migration, unemployment and HIV/AIDS rates, older women's pensions play a very important role in maintaining multi-generational households both during "regular" and "crisis" times.

This paper explores the economic role that older South African and Mozambican women are playing in their households—some of which have experienced an HIV/AIDS death, and some of which have not—in the Agincourt Health and Population Unit (AHPU) study site, an area in the rural northeast of South Africa with approximately 33% HIV/AIDS prevalence (South African Department of Health 2003). In-depth interviews with 30 South African and 30 Mozambican women age 60-75 living in the AHPU fieldsite reveal how they use their pensions to sustain their households and cushion economic shocks.

LITERATURE REVIEW

The South African pension program began in 1928 to benefit the White and Colored populations, and was expanded to the African population in 1944. It was not until the early 1990s, however, that the South African government made a concerted effort to deracialize the grants, further expanding pension access to the majority of Black South Africans (Legido-Quigley 2003). There are a number of restrictions on the national program 1) age eligibility begins at age 60 for women, and 65 for men; 2) the pension is restricted to individuals with a South African identification document; and, 3) there is a means-test, which excludes mostly elderly whites.[1] Only 16% of the White elderly receive a pension, as compared to more than 90% of Black South Africans (Ferreira 1999). The pension can add significantly to the household income of the African population of South Africa. In 1993, it was twice the median per capita income of the African population (Case & Deaton 1998). In 2004, when our fieldwork was conducted, pensioners received R740 per month.

[1] For a description of the structure of the means-test, see Case & Deaton 1998.

In poor households, the pension may serve as a coping strategy for older people and their families. May (2003) found South African pensions to be an important safety net for the elderly and their household members. They provide a reliable and steady source of household income for them. Because a large number of children live in households with elderly, the pensions are able to reach both groups simultaneously. According to Case and Deaton (1998: 1331), "The fraction of children living with a pensioner is highest among children whose household per capita incomes are the lowest, so that the pension not only reaches the households in which children live, but disproportionately reaches poor children." In addition, Case's (2004) research has shown that elderly pensions protect the health of all household members in households that pool income.

As HIV/AIDS strikes prime-age adults, the burden of care, financial, physical and emotional, largely falls to the elderly (Knodel, Watkins, & VanLandingham 2002). The elderly are often left with debts incurred from HIV/AIDS-related illnesses and funeral expenses and with grandchildren (some of whom may be HIV positive) for whom they must now provide and care. Deininger, Garcia & Subbarao (2001) found that grandparents are the primary caregivers for over one-third of orphans in Uganda, Zambia, and rural Tanzania. While the "surviving parent" makes up a large caregiver category, as children become double orphans, the burden is likely to shift further toward grandparents (Ankrah 1993). An investigation of household level coping strategies in the Ugandan context highlights the increased movement of children (Ntozi & Nakayiwa 1999). A recent study by the Kaiser Foundation of HIV/AIDS-affected households in South Africa found that two-thirds had lost income because of HIV/AIDS, almost half reported not having enough food, and approximately a quarter of the children residing in these households had lost at least one parent (Steinberg *et al.* 2002). Given the financial impacts of HIV/AIDS morbidity and mortality, it is likely in a context like South Africa that households will turn to the elderly as a source of financial support, as well as for physical and emotional caregiving.

In the case of HIV/AIDS, and perhaps other types of crises, the burden of caring for a sick individual and orphaned children falls largely to wives and sisters (Dayton & Ainsworth 2002; Knodel, Watkins & VanLandingham 2000). However, Baylies (2002) shows that older women in Zambia are taking on both the roles of caregiver and of advocate for their daughters and women in their communities, by speaking out about the ways gendered practices affect the spread of HIV/AIDS. In addition, older women may be more likely than older men to use their pension in a way that reduces the economic impact of HIV/AIDS. In a study in rural South Africa, Duflo (2003) showed that women's pensions have even more of a redistributive effect than men's pensions.

Women's pensions significantly improve girls' anthropometric status (weight for height and height for age). This result does not hold true for boys, but more importantly, men's pensions have no significant impact on either boys or girls.

Although a great deal of research has yet to be done on the differential spending of pension money by male versus female pensioners, there is an extensive literature on the differential spending of men and women in developing countries. Maitra & Ray (2003) show that in South Africa, the gender of the household head had a significant impact on the spending on certain budget items. Namely, male household heads were more likely to spend money on food, education and fuel, but less on entertainment, clothing and child-care. Case & Deaton (1998) note that it is often found that when women control income, as opposed to men, that more of the income is spent on food. In their study, they found that, conditional on reported income, female household heads spent less on all expenses except insurance and clothing. The largest differences, however, were that they spent considerably less than male household heads on items like alcohol, tobacco and transportation. This literature suggests that men and women spend money in different ways, and may spend their pensions in different ways. In light of these studies and Duflo's (2003) findings, it is important to further investigate ways in which women's pensions may be making important contributions to their households.

An important positive effect of women's pensions is the help they may provide to vulnerable households. However, they may also increase older women's economic burden. Social grants, whether pensions, child grants, or disability grants, are sometimes the most reliable income a household has. Thus, we may see more and more family members turning to and relying on elder women's pensions. This grant, meant to support an elderly individual, may well not be sufficient to support households with numerous members, many of whom are still of school age.

DATA & METHODS

The data for the nested qualitative study analyzed in this paper were collected in the AHPU fieldsite in the northeastern corner of South Africa, bordering on Mozambique. The AHPU site is situated in Mpumalanga Province, which has a HIV/AIDS prevalence rate estimated at 32.6%, making it a highly-affected HIV/AIDS

context (South African Department of Health 2003).[2] High population density and low rainfall make the area inadequate for subsistence farming and more suitable for cattle or game rearing. The eastern edge of the region borders on Kruger National Park, one of the largest game parks in Africa. The population has low levels of education and high rates of unemployment. The most common language is Xitsonga and ethnic identities include Tsonga, Pedi, Sotho, Swazi, and Zulu. Mozambican immigrants to the area speak a dialect of Xitsonga and tend to be classified as Tsonga.

The AHPU runs the longitudinal Agincourt Health and Demographic Surveillance System, for which data has been collected annually since 1992. The AHDSS data include 1) household censuses, 2) updates of vital events, 3) verbal autopsies (VA), and 4) occasional modules on labor migration, household assets, temporary migration, and education. Thus, for each of the 60 households in which we conducted qualitative interviews, we have over ten years of data on all current and past household members—including their births, deaths and movements. As of the annual census in 2003, the study site was home to 70,272 people, in 11,665 households in 21 villages.

We used the AHDSS as a sampling frame to select 60 women between the ages of 60-75 to interview. Forty-nine of the originally sampled women were interviewed with replacement for those that had died, had moved, had had a recent death in the family, refused, were away, or were too sick to be interviewed.[3] The qualitative data were stratified along two lines. First, half of the sample was made up of women native to South Africa, the other half were women born in Mozambique, but who settled in the area during the Mozambican civil war in the 1980s. Although the majority of the Mozambicans living in the AHDSS site have no intention of returning to Mozambique, many still do not have the necessary documentation, a South African Identification Card, to make them eligible to receive pensions or other grants from the South African government.

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[2] During the course of 2005, the Agincourt sub-district, where the AHPU study site is situated, was redistricted from Limpopo Province to Mpumalanga Province. Limpopo has an HIV/AIDS ante-natal prevalence rate of 17.5% compared to Mpumalanga's 32.6%. We cannot know at this time whether the Agincourt sub-district is more similar to Limpopo or Mpumalanga rates.

[3] Among the South African respondents, reasons for not being interviewed included: 1 refusal, 2 with a recent death in the family (we felt it was insensitive to interview in households with a recent death), 2 had died, and 1 had moved out of the household. Among the alternates who were selected as replacements in the South African sample, 2 were not available: 1 had died, 1 was away and was not returning in the course of the study. Among the Mozambicans: 2 were away and were not returning in the course of the study, 2 had died, and 1 was too ill to be interviewed. When we could not interview a respondent, we replaced her with another 60-75 year old woman selected randomly from the AHDSS in the appropriate nativity and household experience of death strata.

In addition to stratifying by nativity, we were able to stratify by the households' mortality experience. Using AHDSS verbal autopsy data, we selected women in ten households where an HIV/AIDS adult death occurred between 2001-2003, ten women in households where a non-HIV/AIDS-related adult death occurred between 2001-2003, and ten women in households where no adult death had occurred during this period.[4] By stratifying the sample in this way, we are able to examine the experiences of households that had suffered an HIV/AIDS death, and compare them to households that had also lost an adult member, but to another cause; and, to those that had no mortality in the four years preceding the study.[5]

We conducted three in-depth semi-structured interviews with each respondent between July and December 2004. Over the three interviews, we asked a battery of questions relating to caregiving of orphans, fostered children, and the sick (mainly adult children suffering from HIV/AIDS). Additionally, we collected extensive information on pension usage during times of crisis and non-crisis times. We are thus able to explore the impact of HIV/AIDS on households, *and* the role that pensions play in both crisis situations (e.g. caregiving for orphans, the sick, and funeral costs) and day-to-day subsistence.

The interviews were conducted by three local women over the age of 40, who were trained by the senior author in qualitative interviewing.[6] Each interviewer was responsible for 20 respondents with whom she conducted all interviews; in addition, each interviewer translated and transcribed her own interviews. While the project was in the field, the senior author read each interview, reviewed queries with the interviewers, and wrote distinctive a unique interview guide for each respondent for the second and third interviews. These guides allowed the senior author to fill gaps, follow up on interesting issues and explore new questions, despite not conducting the interviews herself.

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[4] In the section below, quotes will be followed by a pseudonym for the respondent, her nativity, and the strata into which the household fell. Women who lived in a household with an HIV/AIDS death are identified as 'HIV/AIDS Household.' Women who lived in a household with another type of adult death are identified as 'Other Death Household.' And, women who lived in a household with no death are identified as 'No Death Household.'

[5] We did not conduct interviews in households where a death had occurred in the last 12 months.

[6] The three interviewers were selected from a pool of six applicants. The applicants were interviewed by both authors along with senior administrators from the AHPU. Each applicant was given an interviewing role play in their native language and an English translation task to assess their potential and abilities to work as a qualitative interviewer.

CARING AND CONTRIBUTING

Although the South African government may intend pensions to substitute and supplement income for elderly individuals, the older women in our study are using pensions for much more than their own subsistence. Our respondents who were receiving a pension generally did not see their pensions as money meant specifically for their own upkeep, but rather as a subsidy for the household as a whole, or at least for themselves and their grandchildren. They are using their pensions as means for sustaining their multi-generational households, as a substitute for unemployed children's income, and as a resource for economic shocks. Because of the extensive demands on older women's incomes, very few of our respondents had pension money left at month end. In select Mozambican households, where there was no eligible pensioner, elderly women must seek other coping strategies to sustain their households.

HIV/AIDS constitutes a considerable economic shock to households. The cost of a protracted illness and the loss of income of a prime-aged adult are further compounded by funeral expenses and the need to care for children left behind. These shocks are likely to be even greater when the deceased had contributed income to the household (Hunter & Twine 2005). It is unclear at this stage, however, whether HIV/AIDS affects households differently or more than another type of adult death or other types of economic hardship, e.g. no working prime aged adults. Thus, in the sections below, we speak about how older women in general are using their pensions to care for and contribute to their households. In the final section we highlight how the three strata of households—those with a recent HIV/AIDS death, those with a recent "other" adult death, and those with no experience of adult death—are similar and how they differ.

Mozambican Pensioners

The original impetus for stratifying the sample by nativity was driven by the idea that Mozambicans are thought of as "more vulnerable" members of the Agincourt population because of their difficulties accessing pensions and other social grants. Once we began interviewing the Mozambican respondents, however, two things became clear: 1) they were very wary of being interviewed and worried that we were interested in deporting them, and 2) the majority of them had managed over the years, some through legal and some through extra-legal means, to obtain South African identification documents. A full two-thirds of the Mozambican women with whom we

spoke had a South African ID book and were receiving a South African government social grant (as seen in Table 1).

Table 1: Nativity and Pension Receipt

Nativity	Receiving SA Old Ag	Receiving SA Disabil	Not Receiving SA Go Grant
South African	26	3	1
Mozambican	19	1	10

Although we were surprised that two-thirds of our Mozambican respondents had ID books and were receiving the pension, given that they *are* legally eligible to have a South African ID and receive the pension, it is disheartening that a considerable number of Mozambicans do not have a South African ID book, and thus are not able to access government funding. Legal reality aside, there are many Mozambicans who believe that it is difficult, or even illegal, to obtain South African documentation due to their nativity. As one respondent said, "[It is difficult to get SA-ID books] because we are not legally allowed to have a South African ID document" (Jane, Mozambican, Other Death Household). When asked why she had not applied for a South African ID, another respondent said, "I don't have money to apply for an ID, but it is difficult to find an ID if you are from Mozambique. I did try to apply but I failed" (Refilwe, Mozambican, No Death Household).

One obstacle appears to be ease of applying for and obtaining an ID book. Several women, both those who were successful in getting an ID and those who were still without, said that they had to apply for an ID at home affairs more than once. "I applied for an ID first at Nelspruit. I didn't get it. I applied for a second ID at Hazyview. I got it. They never asked me where I came from" (Loveness, Mozambican, No Death Household). Another respondent has yet to be successful, "I applied for the first ID at Home Affairs at Thulamahashi, but I never got an ID. The second ID, I applied at Mkhuhl. I never got it." (Abigail, Mozambican, Other Death Household)

Another barrier to obtaining an ID book may be financial, as Refilwe mentioned above. Each of the 20 respondents who had IDs gave different stories of how much they paid for the document, if they paid at all. Some paid just R20 for the photograph to put in the ID book, others paid R200-300 to someone at Home Affairs. It was unclear in most of the interviews whether the respondents think they paid an official fee or a bribe. One respondent found out it was a bribe only after she lost her money:

> I: What was the process you had to go through to get an ID book? R: Myself, I go to Nelspruit for the first time to apply the ID, but I never got the ID. I gave them R200. I: To whom did you give the money? R: The people who were working in Home Affairs, two of them. I: Tell me the story what happened about your R200? R: When I geve them the R200, I never got the South African ID. Those people were arrested because of robbery of ID books. I: What other steps have you done to get the ID you are now having? R: For the second time I went to Thulamahashi Home Affairs where I gave them R300 and I got the South African ID within three months. (Linda, Mozambican, No Death Household)

Despite beliefs that obtaining an ID might be illegal, difficult, take a few tries, or cost some money, all of the Mozambican respondents desired a South African ID. Those who did not have one at the time of the interview said they were in the process of applying, were planning to apply, or asked for assistance in applying. The main reason that all respondents mentioned for wanting an ID was to gain access to the pension. "I wanted an SA-ID in order to get a pension with it." (Nelly, Mozambican, HIV/AIDS Household).

Sustaining Households

As suggested by both the literature on pension use and gendered spending patterns (Case & Deaton 1998, Case 2004, Duflo 2003, Ferrria 2004, Maitra & Ray 2003), older women are very likely to pool their pensions with other household income in order to feed, clothe, and shelter their kin, and less likely to spend it on luxury items like alcohol and tobacco. When asked who the pension is for, the overwhelming response from nearly all pensioners was "for me and my grandchildren" or "for me and my family." As one Mozambican woman said, "To me is not good when someone is receiving pension and not supporting her children" (Mkateko, Mozambican, Other Death Household).

The few who did not give this response were more likely to be living by themselves or with just one of their children and with no kin under the age of 15 in the house. Women primarily reported supporting family members (children and grandchildren) living in the same household, but some supported those living elsewhere. Alucia, one of the Mozambican's receiving a pension, lives with four family members, but shares her pension more widely. She sometimes gives R200 to her son who is not working, she said, "I said when I get pension, I give all my children. I give them because I want them to know that I'm getting government money… [I give my daughters R100 each.]…They use the money at their places. I never give in order to know what they want to buy" (Alucia, Mozambican, HIV/AIDS Household). Some respondents also suggested that they sometimes use their money to help kin outside of their household in case of a death or other crisis. For example, Anna, who has not had a death within her own household said, "If I don't have problems of funerals for relatives, I use the money

until I receive for the following month. If there is death, I ought to donate and remain without money" (Anna, South African, No Death Household).

The pensioners reported primarily spending pension money on household essentials. These essentials include groceries, clothing, electricity, blankets, building materials, and other non-luxury items. When we asked Eleanor, a 69 year old widow who is supporting one daughter and four grandchildren, one of whom is a paternal orphan, how she uses her pension money after she receives it from the cashier, she said, "Firstly, I pay for my funeral society, buy peanuts, tomatoes, cabbages, and chicken. Then when I arrive home, I send my grandchild to go and buy a bag of mealie-meal and electricity" (Eleanor, South African, Other Death Household). Women reported spending very little money on "luxuries," and when asked what luxuries they did occasionally indulge in, they reported items like cold drinks, meat or clothes for themselves, children or grandchildren. When asked how they ideally would like to spend their pension money, most women mentioned improving their housing situation and buying major household items, like furniture.

The picture this presents is of altruistic women who feel their pension belongs to their children and grandchildren, as well as themselves. Women report using pensions in order to support kin within their households on a regular basis *and* in crisis situations. And, women who use most of their pension money to sustain households are buying necessity items—groceries, clothing, school fees—rather than "luxuries" or items on which they had hoped to spend money.

Substituting Missing Incomes

Although HIV/AIDS and other causes of death have a strong impact on households' economic well-being, another major stressor seems to be unemployment. The unemployment rate in the area is very high, upwards of 30-40%. Very few of our respondents said that all of their children were working; the few that did seemed exceptionally proud and felt people were jealous of their good fortune. As one of the Mozambican respondents explained, "Jealousy is always in every human being. If you receive pension, other people are not happy. I think that they are jealous because my children are all working and I am getting pension" (Portia, Mozambican, No Death Household).

The majority of respondents had at least one child who was unemployed at the time of the interview. Some of these children live in their mothers' households, others are in nearby towns or further off cities trying to

find employment. Sometimes the pensioners send money to their children living in towns or cities to support them until they find employment.

Nearly all respondents who lived with unemployed children felt their pension should be used as a replacement for children's income. Emily, a divorced 65 years old lives with a daughter and three grandchildren. Despite being from a household where there was no death between 2001-2003, Emily's pension is not used by her alone. When asked who benefits from her pension, she answered, "Me and my grandchildren, and my daughters because they are not working" (Emily, South African, No Death Household). Having unemployed children also obviously means that the respondents are not getting support from these children, something that may have been expected by parents who invested in education or other forms of training. Several women asked our interviewers if we could help find jobs for their children.

Cushioning Economic Shocks

The women with whom we spoke had suffered various economic (and emotional) shocks, including the illnesses and deaths of spouses, children and grandchildren, the loss of income from children's jobs as they are retrenched or unable to find work, and the addition of household members for whom they must care both physically and financially. Nelly sums up such change:

> Before I got pension, life was easy because my husband was working in Johannesburg and he was taking care of me. When he was old, he was getting pension and when my son was working, he was supporting us. But when I started receiving pension, life became worse because my husband and son died. Now I must take care of my grandchildren and other children of my husband with my pension money of R740 and things are very expensive (Nelly, Mozambican, HIV/AIDS Household).

Despite the many possible economic shocks, or perhaps in anticipation of them, many women were investing in various insurance or credit programs to cushion such shocks. Fewer of the Mozambican than South African women were members of either burial societies or rotating credit schemes. As mentioned above in the quote from Eleanor, one of the first things that she pays for after collecting her pension money is her "funeral society" or burial society. It is unclear from the interviews whether the burial societies are a response to the increasing death rates in the area, or how popular they were before HIV/AIDS began encroaching on the area.

Many of the pensioners paid out R40-70 per month in order to have insurance if they or a close family member dies. The benefits of the programs differ from one insurance company to another, but generally each

provides a coffin, some transport, and some food for the mourning period. Sister, a 67 year-old widow, living in a household with 13 of her kin, explained who she registered and what the benefits are of her burial society:

> I: Do you have a burial society? R: Yes, I do. I: So how much do you pay? R: I pay R60 per month. I: Who have you registered? R: I have registered all my children under 21 years and all my grandchildren. Those are staying here with me. I: Why have you chosen these people? R: Because I'm the one who takes care of them. So everything that will happen to them, I am the only one to deal with it. I: What is the reward if one died? R: They give R3000,00 only" (Sister, South African, HIV/AIDS Household).

Most of the female pensioners also invested in rotating credit schemes. Rotating credit schemes work in the following way: every month all of the members of the group invest the designated amount of money, each month one of the women is given the pot of money to spend as she wishes. Many of the rotating credit schemes our respondents discussed were created just among a group of a few friends, usually with other pensioners or social grant recipients. Women invested anywhere between R50-200 per month into such schemes. Usually when their turn arrived, they used the money to buy a larger item for their house like cement for building, or iron for a roof, or a wardrobe or bed.

In addition to using pension money to buy forms of "insurance," pension money also went directly toward paying bills associated with illness and funerals. Rebecca, a 65 year old widow, who was supporting two grandchildren, the wife of one of her grandchildren and six great grandchildren, felt that she could not afford to pay for a burial society, "I am interested in joining but the money I get is too little, because I am the only one who takes care of the children" (Rebecca, South African, Other Death Household). Rebecca's son died a number of years ago, but she continues to struggle to take care of her grandchildren and great grandchildren. When asked whether the economic status of her household had improved since her son's sickness and death, Rebecca responded, "Aaa! It was difficult, but it is better [now] because of the pension I receive" (Rebecca, South African, Other Death Household).

One of the main differences between households that had experienced an HIV/AIDS death and other households was the need to borrow money to pay for the costs of illness and funerals. Several respondents in households that had not experienced an adult death had borrowed money to help with the funerals of children's spouses or other family members. In both strata 1 (HIV/AIDS death) and 2 (other death), more women spoke of needing to borrow money from neighbors or other community members in order to pay for the funeral of a child or spouse. Respondents in HIV/AIDS households also discussed the costs of illness, a couple even resorted to borrowing money from *machonisa* [money lenders] to be able to bury their kin. Sister, is one example:

> Hey! June was a terrible month for me because I was busy paying the money that I borrowed from *machonisa* [money lenders]…. [The] people who lend people money and you must pay interest. Then I was left with little money for the groceries. … [I borrowed money from *machonisa*] because of the death of my son. I wanted to bury him. … [Neither of my two sons who died belonged to a burial society.] No, I went to a *machonisa* to borrow R3,000 for [my first son who died] and R7,000 for [the second], and relatives helped me to bury them (Rebecca, South African, HIV/AIDS Household).

One of the difficulties in differentiating between households is the fact that many of the women we interviewed have inter-household connections to children and grandchildren who do not live in their household. Thus, women whose households had not had a death may have experienced the death of a non-resident child or other kin during the designated period. The unfortunate reality is that they too may have expenses related to burial and mourning.

"Leftovers? Noo!"

Very few women had any money left at the end of a payment period. As mentioned above, most money went to sustaining households—making sure there was enough food and clothing for household members, and that school fees were paid. For example, Anna, a 74 year old divorcee who lives with her son, his wife, and their two small children explained, "I spend the whole money to buy everything [needed] at home because no one in the house is working." (Anna, South African, No Death Household). Eleanor echoes Anna's claims, but for different reasons, "I don't have leftovers because I must buy clothes for the child whose father died and also pay the school fund" (Eleanor, South African, Other Death Household). Finally, Emily explains how sometimes there is not enough money to cover all her needs, "[There are] no leftovers… Haa! Things are too expensive nowadays; 80kg of Tafelberg [mealie-meal] is R250.00, 12.5 kg of sugar is R57.00, washing soap is R40.00, also electricity and groceries. My last born was supposed to be at school but I don't have money to pay for her" (Emily, South African, No Death Household).

When asked about what "leftovers" there were, a few respondents mentioned having R100 left when the next pay day arrived. Most of those who did not spend their entire pension within the month had assistance from children who were working, or were not responsible for supporting large numbers of grandchildren. Those who were able to save did so in different ways. Some of these women had savings accounts through the post office, like Eunice: "I buy groceries but my son helps me and I also buy blankets and clothes for myself, and the remaining money I put in the post bank." (Eunice, Mozambican, Stratum1). Others hide the extra money in their home. For example, Ester said she hides her leftover pension money "inside my house in a small bag." She said

she is saving "to buy what I want, e.g. like washing soap. I don't want to ask soap from anyone, like buying meat." (Ester, Mozambican, Other Death Household). Some of the women who tried to put money aside to save sometimes dipped into their savings: "I use my money for up to three weeks, but I keep R200 every month for sickness. But I have received my pension money on August 2. Now the money is finished. Even the R200 I kept, I have used. I'm waiting to get other money on September 3rd" (Auphrey, South African, HIV/AIDS Household).

The majority of women, however, claimed that not only did they *not* have money left when the next pay day arrived, but that they ran out of money a week or two before the next pay day. Dudu, who lives in a very large household with 25 members, alluded to using up her money the day she receives it. "I: After receiving pension, what do you do first? R: I buy 80kg of mealie-meal, peanuts, beans, cooking oil, tea and 12.5kg sugar. I: After buying all these, do you have leftovers? R: No leftovers. As I am speaking I don't have anything in my pocket. Maybe if I was receiving help from others, there will be leftovers" (Dudu, Mozambican, No Death Household). When asked at what point her money runs out, Maria, a divorced 67 year old woman, who lives with two orphaned grandchildren, her son and one of his children, said, "Hiii. Even now I am penniless, but it is the third week of the month and I'm going to receive another pension on the seventh of next month. But now I don't have anything in my pocket" (Maria, South African, Other Death Household).

Although most of the pensioners mainly used their government grant to cover household necessities, many found that it was not enough to sustain their family through an entire month. Often at month's end women find themselves without "anything in their pockets." The most common response, when asked what the government could do to help the respondent and her family, was to "add money" to her pension. If older women are really as responsible with their pension money as they appear from our 60 interviews, increasing the pension may be one way to get more money into poor households and helping poor children.

Households without pensions

As mentioned earlier, not all of the women with whom we talked collected a pension. One of the South African and one-third of the Mozambicans respondents were not receiving the pension or a disability grant. Cynthia, whose husband was receiving the pension, claimed that she was not able to access a pension because her age had been "cut" on her ID book, i.e. her ID book listed her age as younger than she is. The majority of the

Mozambicans were not getting the pension because of their difficulties in obtaining a South African ID, as discussed in an earlier section. Whatever the reason for not getting a pension, these women largely felt that it was unfair that their peers were getting money from the government to help their families, and they were not. Jane is a Mozambican woman whose son helped her get a South African ID book, but when the ID book arrived, it had the wrong birth date, "cutting" her age. She claims that it is unfair that some people get pensions and others do not, "because they are getting money to buy enough food, but myself I am suffering. I have no food to eat." She went on to explain how hard it is to take care of the two foster children she is responsible for, "It is too difficult because I don't have money to buy food for them or even to pay school fees" (Jane, Mozambican, Other Death Household).

Most of the women who were not getting a pension claimed that they wanted to receive a pension to use for many of the same household essentials on which pensioners spent their money. Some of them said that they wanted to be like other grandmothers and help their children and grandchildren. Abigail, "If I was getting pension, I would buy clothes and a bed to sleep. But now money becomes a problem to me to get it. Even my grandchildren, I want to give to them like what other *gogos* [grandmothers] are doing to their grandchildren" (Abigail, Mozambican, Other Death Household).

In households where there is no pensioner, like many of the Mozambican households, women are more likely to be doing temporary labor and looking to family and neighbors for support. Linah stays with her sick co-wife, her co-wife's son, two of her own daughters, and two grandchildren. She described how her very poor household finds money, "Some other people call us to give us temporary jobs and [they pay us with] mealie-meal. ... I'm not getting support from family members or relatives because they are also poor. They are not working" (Linah, Mozambican, Other Death Household).

Lilly, age 73, lives with 19 kin, but is only supporting her last born child. She survives with the assistance of her sons and a monthly payment from her former place of work, compensation from her hand being broken in a tractor accident.

> So my hand was broken. Then my boss took me to the hospital. And the doctor said that I must stay at home a month in order to recover. So when I went back to my work, my boss said that there is no more [jobs]. So I went back to my home until now. … [After it happened,] I went to a social worker to explain what happened. So the social worker wrote a letter to my boss, demanding him to pay me for the accident. I came across, so now he is paying me R260 per month. …

> My sons and my R260 are what support me. … I buy mealie-meal, soap, cooking oil, and other groceries for the house. As I told you that we do share with my son. … [Last month,] I took R100 to buy a goat and the rest I used to buy other needs for the house. …I do not [have leftovers] because I do receive a small amount of money.

Although Lilly gets assistance from her children and from her former place of work, she lives on very little money each month. If she had not broken her hand, it is likely that she would still be working.

Living alone after the death of her son and her daughter-in-law leaving for her own compound, Qeliwe's situation is equally if not more desperate:

> I: Where do you get money to buy food? R: I don't have money to buy food. I even don't have food to eat, my daughter. Some other days, I sleep without eating anything. I: Where does your granddaughter get the food that she gives you because you said that their father has passed away? R: Their mother (my daughter) is receiving pension. I: Is your daughter receiving the old age pension or disability grant? R: The disability grant. After receiving the grant, she gives me money to buy snuff. Also she gives me meat , that is, they give me raw, so that I may cook it (Qeliwe, Mozambican, HIV/AIDS Household).

Despite not having other people to support, Qeliwe often goes hungry. Clearly older women who are unable to access the pension, particularly those without working children, are particularly vulnerable. Qeliwe's situation was made worse by the hardships she experienced while caring for her son, who she said died of TB, but the AHDSS verbal autopsy reports the cause of death as HIV/AIDS:

> When it started he didn't have appetite, he wanted to drink water only. He didn't have to eat food. He became weak. When you asked me about it, my heart becomes painful, my daughter. He died on the way to a *sangoma* [traditional healer]. He was on my back because I did not have transport to take him to the *sangoma*. On the way, I fell down with him. [Qeliwe started to cry, the interviewer comforted her.] When you comfort me, I feel as if I can see my son. Because he left me poor, as I am, I am suffering, my daughter. (Qeliwe, Mozambican, HIV/AIDS Household).

END PARAGRAPH

CONCLUDING THOUGHTS

In this paper we have looked at living arrangements and support from the vantage point of the grandmother who is eligible for pension support. What stands out about the narratives of the women in this study are not the differences between the Mozambicans and South Africans, nor are there abundant differences between those women with different experiences of an adult death in their households. What *is* striking, however, is the dominant nature of poverty in all of these women's lives. Pensions are making a meaningful and important contribution to the women and households in our sample, and those not receiving a pension are usually at a significant disadvantage.

Poverty defines our sample in ways that the predefined strata do not. As important as the experience of an adult HIV/AIDS death, or even another type of adult death, may be to impacting a household economically, a woman's ability to cope with this impact has as much to do with her situation in absence of this event as the event itself. The number of kin the grandmother is supporting in conjunction with the number of other members in the household or outside the household who are helping to support her are central to her household's economic well-being. Women may use all their money helping to nurse and bury one of their children who was infected with HIV/AIDS. But this scenario is not limited to deaths that occur within the household. The infected son or daughter could be infected, living, be ill, and die elsewhere.

Poor households also crop up when a grandmother is caring for a number of her daughters' children from non-marital births, or when a grandmother's is the sole steady income in a household with many unemployed adults. In addition, poor households appear when a grandmother, sometimes one earning a pension, but more often a woman who has not been able to obtain a pension, is alone and not getting any assistance from her children. Even those women who might be considered wealthy and lucky by local standards—those with two pensioners in a household and a number of adult children working in the formal sector—are far from wealthy by Western standards. Even these "wealthy" women spoke in our interviews of wishing they could save more and provide more assistance to their kin. They, like those who sometimes went hungry, wanted a pension, needed a pension, and when asked what the government could do for them, nearly all of our respondents said, "add money to my pension."

Meeting the request to "add money" to pensions may be a very real way to improve the welfare of households with a pensioner and children under age 15, reaching both demographic groups simultaneously. In future work, we plan to analyze data from the Agincourt Health and Demographic surveillance system to determine the proportion of children who live in households with pension age-eligible adults to determine the extent to which children would be affected by a policy which increased pensions to elders. Focusing policies and interventions just on households that have experienced an HIV/AIDS death, or those that are supporting AIDS orphans may reach certain very needy individuals, but is also likely to overlook others who are also very in need. Targeting all grandmothers (and grandfathers) by increasing the pension might be a better way to assist vulnerable children and elders.

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