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Caregivers' Sacrifices: The Opportunity Costs of Adult Morbidity and Mortality on Female Pensioners in Rural South Africa

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ABSTRACT

This paper explores the impact of adult morbidity and mortality on the socioeconomic well-being of female pensioners and their households. As mortality rates escalate from HIV/AIDS and other causes, older women are bearing the brunt of responsibilities related to caregiving for the sick and orphaned. These women often use their state funded non-contributory pensions during crises related to caregiving. The authors conducted in-depth semi-structured interviews with 30 women aged 60-75 in the MRC/Wits Rural Public Health and Health Transitions Research Unit (Agincourt) study site in northeast South Africa. They found that, in order to cover expenses incurred during crises, older women sometimes forego spending money and time on their personal needs, thus producing negative effects for them as individuals while they are contributing positively to the household. Despite the additional household income that pensions provide, many of the study respondents still found it difficult to recover from the financial impact of these crises.

INTRODUCTION

Sustained progress in development and access to health services throughout the world has not prevented an increase in mortality rates in sub-Saharan Africa of prime-aged adults and children under age-five. This increase is largely due to communicable diseases such as tuberculosis, malaria, hepatitis B, lower respiratory infections, and perhaps most conspicuously, HIV/AIDS (Murray & Lopez, 1997; World Bank, 1993). The increase in mortality from these diseases is reinforcing social and economic inequalities; in South Africa, the impacts of HIV/AIDS “travel” along paths of inequality created by apartheid (Albertyn, 2003).

In sub-Saharan Africa, women are more likely than men to be caregivers of the sick since gender roles often determine household members’ duties. As tuberculosis, malaria and maternal mortality continue to plague rural African populations; and, as more young men and women are falling prey to the HIV/AIDS epidemic, older women are more likely to be asked to provide care for the ill and orphans left behind (Ferreira, 2004; HelpAge International [HAI], 2003; Schatz & Ogunmefun, *in press*). As caregivers, some losses incurred include income (earnings forgone as they stay at home to give care), savings, wealth, assets, and health (due to stress and strain). Increases in expenditures on health care, funeral costs and payment of debts strain already thin household budgets that must cover food, housing, and education expenses (HAI, 2003; Knodel & Im-em, 2003; World Health Organization [WHO], 2002).

In South Africa, older women have access to a non-contributory pension, which the South African government extended to the black South African population at an equal rate as given to white South Africans in order to address poverty and inequalities created by apartheid (Legido-Quigley, 2003). The implication of this is that families may turn to the elderly not just

for physical and emotional support as the epidemic impacts communities and households, but also for economic support.

In many households, the pension is the primary source of income for older people and their families (Duflo, 2003; Legido-Quigley, 2003; Sagner & Mtati, 1999). Despite the fact that these grants are meant for the upkeep of the elderly after they are too old to work or earn their own incomes, this study, and several others, provide evidence that they are using this money to support their households, especially when there is an HIV/AIDS-related illness and death (Duflo, 2003; Ferreira, 2000; HelpAge, 2003; May, 2003). The implication of this is that the HIV/AIDS epidemic may undermine the efforts being made the government to redress the inequalities created by apartheid by forcing the elderly to use economic resources meant to alleviate their own poverty, to assist the needs of their families (Albertyn, 2003). Specifically, our data show that female pensioners are using their social grants to reduce financial burdens associated with adult illness and death, especially HIV/AIDS related morbidity and mortality, rather than alleviating poverty.

OBJECTIVES

This paper explores the impact of adult morbidity and morbidity on the socioeconomic well-being of older women and their households in the MRC/Wits Rural Public Health and Health Transitions Research Unit (Agincourt) study site, based in the rural northeast of South Africa. Since poverty is endemic in much of rural South Africa, many rural older black South Africans receive the means-tested pension. We explore how older women's pension usage mediates the financial impacts of crises brought about by morbidity and mortality in their families and households. When family and household members rely on older women's pensions

during crises, our respondents at times put their family's and households' needs before their own. Therefore, we focus on the opportunity costs of caregiving and their impact on older women's financial well-being. We hypothesize that as older women take care of the needs of their family and household members, some of their own needs are left unmet.

BACKGROUND

Increasingly evidence shows that gender roles related to caregiving may be changing in the context of HIV such that men are becoming more involved (Ogden et al., 2004). It is however women, particularly elderly women, who are principal caregivers in most homes when there is a sick or dying adult (Barnet & Whiteside, 2002; Ferreira, 2004; WHO, 2002). As caregivers, older women "bear the greatest degree of responsibility for the psychosocial and physical care of family and community members" and as a result they are increasingly vulnerable to illness and poverty (Ogden et al., 2004), particularly in sub-Saharan Africa. These responsibilities make pensions or other cash transfer programs, where available, an important resource for coping with the burden of caregiving (HAI, 2005).

South Africa is one of the few countries in sub-Saharan Africa in which the government provides a number of social grants programs meant to alleviate poverty and redistribute income to the poor. These include a disability, child support and foster-care grant, and an old age pension. The child support, foster care and disability grants all target poor children, with the grant being designated for a specific child, though the grant recipient is usually the child's parent or guardian. The old-age pension targets the elderly, that is, men over age 65 and women over age 60. It is non-contributory, making it available to age-eligible women and men regardless of work history. Although the grants are means-tested, the test is rarely administered to those who appear poor (Lam

et al., 2005; Legido-Quigley, 2003). In 2004, the old-age and disability grants were SAR740 (approximately US\$105) per month while the foster care and child support grants were SAR530 (approximately US\$75) and SAR170 (approximately US\$25) per month respectively (Department of Social Development, 2006). These grants are sometimes households most reliable and stable income (May, 2003; Moller & Ferreira, 2003).

Old-age pensions play an important role in South African social support networks (Lam et al., 2005). This is particularly true for elderly black South Africans, most of whom reside in extended multigenerational households (Noumbissi & Zuberi, 2001). Pensions give the elderly the opportunity, or perhaps place pressure on them, to share their grant with other members of their household. According to HelpAge International (HAI) (2003), the South African pension grant, which is meant for the elderly, is usually shared between the recipient and household members. Thus, old-age pensions may serve as an important safety net for South African families and households in both everyday survival and during financial crises (May, 2003).

According to the Department of Welfare (1997), the majority of South Africans who live in multigenerational households are poor and therefore the old-age grant “is typically turned over for general family use.” There are over 1.9 million beneficiaries of the old-age grant, nearly three-quarters of whom are women (Social Development Report, 2002). Case & Deaton (1998) and Duflo (2003) provide further evidence that South African older women share their grants with their households, often resulting in improved outcomes for children, particularly girls, living in their households. As a result of pooling pensions with other household income, South African households with pensioners have greater financial stability and lower probability of experiencing a decline in living standards when income-earning adults become incapacitated and die, whether from HIV/AIDS related illnesses or other ailments (Barrientos et al., 2003).

Pensions serve as a stable and reliable income for older people and their families to alleviate poverty, as well as mediate crises (Booyesen, 2004). These crises include the need to use pensions to substitute for income of unemployed prime-aged adults (Ferreira, 2000; Sagner & Mtati, 1999; Schatz & Ogunmefun, *in press*), as well as the costs associated with morbidity and mortality (Steinberg et al., 2002). As more young people are infected with HIV/AIDS, the need for pension grants to serve as a safety net is more cogent. Although in many ways pensions alleviate strains on households, an individual's access to a pension may increase a household's dependence on him/her.

This paper explores the ways in which family or household members' morbidity and mortality may increase financial burdens felt by older women, who are pension recipients, while pensions simultaneously decrease the household-level financial impacts of the disease. Although both male and female pensioners may contribute their social grants to household expenses, evidence from South Africa shows that women are more likely to be contributing money and time to caregiving (Duflo, 2003; Ferreira, 2004). In particular, older women are more likely than their male counterparts to take on responsibilities of caring for the sick, dying children and orphaned grandchildren (Ferreira, 2004). Since they are often very physically close to the ill and children left-behind, they may feel a greater responsibility to use their pension grants for health care costs, funeral costs, lingering debts (Knodel & Im-em, 2003) and to care for grandchildren left-behind (Schatz & Ogunmefun, *in press*). Kin in most contexts provide instrumental support, feeling an obligation to family and giving assistance when it is needed (Rogers, 1996), which usually entails rewards as well as costs (Rook, 1984). Older women may feel "bound" to support their kin (Schatz, *in press*), and thus do so willingly and receive gratification and other positive rewards; there are, however, certain opportunity costs associated with their altruism.

DATA AND METHODS

We collected the data for the qualitative research analyzed in this study, in the Medical Research Council/Wits Rural Public Health and Health Transitions Research Unit (Agincourt) field site situated in the Mpumalanga Province, in the rural north-eastern part of South Africa, bordering on Mozambique. The MRC/Wits Unit, based in the University of the Witwatersrand's School of Public Health, established the Agincourt Health and Demographic Surveillance System (AHDSS) in 1992 to provide information on health status and population dynamics of rural communities (Collinson et al., 2002). Since 1992 the unit has conducted annual household censuses, updates of vital events, and occasional modules on labor migration, household assets, temporary migration, and food security. The MRC/Wits unit also conducts verbal autopsies to identify the cause of each death in the study site (Kahn et al., 2000).

In 2003, the AHDSS population was about 70,272 people that resided in 11,665 households. Residents of the site are Shangaan-speaking. The population density is 172 persons per square kilometer, in a 500 square-kilometer area made up of 21 villages. Due to high population density and low rainfall, the area is suitable for cattle or game rearing but inadequate for subsistence farming; however, most families farm small plots for household use. The output of these small gardens is insufficient to cover household food needs (Hunter & Twine, 2005). Mpumalanga Province has a high HIV/AIDS antenatal prevalence rate; in 2004 when our study was conducted the prevalence rate was 30.8% (Department of Health, 2005).

Using the AHDSS 2003 census as a sampling frame, we selected a random-stratified sample of 30 households in which women aged 60-75 years lived. If more than one woman 60-75 years old lived in a household, we randomly selected one respondent. Between July and September 2004, we

conducted three in-depth semi-structured interviews with each of 30 respondents. The interview guides included a battery of questions related to pension usage, caregiving of the sick and orphan/fostered children, beliefs about and experiences with HIV/AIDS, and the socioeconomic impact of the epidemic on our respondents' lives. The interviews were conducted by three local interviewers who taped and fully transcribed all the transcripts. Before interviews were conducted, the interviewers obtained informed verbal consent from the respondents. The interviews were coded by the authors using Nvivo to conduct content analysis on emergent themes. [See Schatz & Ogunmefun, *in press*, for a fuller discussion of response rates and study design.]

The study sample is stratified by household mortality experience. Using verbal autopsy data from 2001-2003, we randomly selected households in three categories, such that one-third of our respondents lived in households that had experienced an adult HIV/AIDS death, one-third lived in households where an adult death from another cause had occurred, and one-third from households with no adult death during the designated period. We did not interview in households that had experienced a death in the six-months preceding the study out of respect for local mourning practices.

Despite stratifying the sample in this way, we found that the majority of our respondents had experienced the illness or death of a family member (some of whom did not live in our respondents' households and thus were not captured in our stratification scheme) in the present or recent past. There were several scenarios that connected our respondents to someone who was currently ill or had recently died. These included: (1) a relative within or in another household was currently sick, (2) an adult child living in another household was sick or had died in the preceding 5 years, or (3) the household took in children during the illness or after the death of a relative who lived in another household. In many of these cases, the illness affecting the family

and our respondent was HIV/AIDS. Although, a high rate of violence and accidents also continue to be significant causes of death among young people in this population (Kahn et al. 2000). Although there is evidence that over time HIV/AIDS will have a profound effect on our respondents' households, in this paper we discuss the impacts of morbidity and mortality more generally.

RESULTS

Morbidity and mortality impact not only individuals, but also their families and communities. The current burden of disease in rural South Africa is such that to a large extent, it is prime-age adults who are dying and older (or younger) kin are the ones left with multiple burdens of caregiving. Older people, particularly women aged 60 and above, primarily experience household members' morbidity and mortality through interactions with children or family members who are sick or dying (Schatz & Ogunmefun, *in press*). In many cases, older women are becoming caregivers for the sick, children of the sick and orphans (HelpAge, 2003; Knodel, Watkins & VanLandingham, 2002; WHO, 2002).

Most of our respondents mentioned that, at one point in time, they had taken care of an ill child, while a few helped to care for other kin such as grandchildren, spouses, daughters-in-law and siblings, some of whom were sick with HIV/AIDS, others with non-HIV/AIDS related illnesses (See Schatz, *in press*, for more description of caregiving responsibilities). In most cases, while caring for sick adult children, our respondents also took over the responsibility of caring for the children of the sick; with the death of the respondent's child, the responsibilities for caring for left-behind grandchildren continued. Even though some of the respondents said that relatives assisted them with the physical and financial responsibilities of caregiving, the bulk of

the responsibility fell on them. Many even believed caregiving is their responsibility as mothers, regardless of the age of their sick children (Schatz, *in press*). As a result of caregiving responsibilities, most of these women experienced financial difficulties.

Even though our respondents' interactions with their children and other family members could sometimes be negative, there is evidence of an intergenerational support exchange, which yield some positive outcomes. Some of the respondents reported that they sometimes receive support from their children and grandchildren in cash and in-kind (See Schatz, *in press*); however, the support and care the elderly provide in return may heighten their level of stress.

The majority of our respondents (29 out of 30) were receiving a government old-age pension. Under normal circumstances, they use their pensions to sustain their multi-generational households and as a substitute for missing incomes (e.g., unemployed children's income) (Schatz & Ogunmefun, *in press*). HIV/AIDS, other illnesses and death cause further household expenses for which our respondents take responsibility. When their sick children do not have money of their own, our respondents use their pension money to pay for the treatment of sick children, mourning and funeral costs, and expenses incurred when caring for fostered and orphan children (Schatz, *in press*).

In the sections below, using narratives from our respondents, we focus on the financial difficulties experienced by older women when they use their pensions to take care of expenses related to adult morbidity and mortality in their families and households. We look at how our respondents use their pensions to pay hospital bills, traditional healers, funeral and mourning expenses and also to support fostered and orphaned grandchildren. We also highlight the lasting financial impact of adult morbidity and mortality such as lingering debt, selling assets and living

on credit. Through our respondents' narratives, we show how their altruistic behavior impacts their own lives and well-being.

Socioeconomic Status of Households

Below we show the wealth level of our respondents' households. We created an index while in the field by asking our interviewers to create a wealth index for our 30 study-households that was based on household size and appearance.¹ After assessing size and appearance of wealth, the interviewers used an internal comparison to put each household into a below average, average, or above average category.

Table 1 about here

Table 1 shows these wealth rankings by household mortality experience. Households that had had an HIV/AIDS death were more likely to be categorised as below average than households with another adult death or no death. This is significant finding suggests that households with an HIV/AIDS death have been at risk for more morbidity and mortality related expenditures, and at risk for having more difficulty recovering from such crises. Households that were categorised as above average or average were equally distributed across the three SES categories.

The sections below outline the financial and opportunity costs faced by our respondents, and their ability to recover from crises caused by adult morbidity and mortality in their families and

¹ We compared the data we collected to the respondents' socioeconomic status (SES) as measured by the MRC/Wits Unit in the 2003 household asset index. Although we found some correlation between the measures, there were many differences. There are two issues that may have caused these differences, First, the AHDSS data were collected in 2003, a year prior to our interviews, thus changes to household SES might have occurred over the course of that year. Second, the AHDSS data compute SES at a household level, although our interviewers also looked as a household as a whole, their SES index focused on the well-being of our respondents. Since many households do not share resources equally among household members, it is possible that some of the discrepancies result from the fact that our respondents did not have access to household-wide assets. Thus, we are relying on our interviewers' internal scoring for our SES index.

households. Quotes from our respondents will be followed by a pseudonym, their socioeconomic status, as determined by interviewer's ranking, and the households' mortality experience.

Financial and Opportunity Costs

When older women take over the responsibility of caring for the sick, fostered children and orphans, there are many related financial and opportunity costs. Some of the financial costs include taking care of expenses incurred by sick adult children, mourning and funerals (when patients die), providing financial support for fostered children and orphans. The opportunity costs are such that our respondents forego some necessities in order to take care of the expenses mentioned above, for example, they put off renovating their houses, which are at times in desperate need of repair.

Providing Physical Care for the Sick: When adult children become sick, older women often take over the physical responsibilities of caregiving. Nearly all of our respondents had at some point taken on the day-to-day tasks of caregiving for a sick family member. Most of our respondents also reported that they had taken care of fostered and orphaned children (Schatz, *in press*). Caregiving is physically and emotionally demanding for elderly women.

There are also considerable time commitments related to caregiving. When caregiving takes precedence, other income-generating or resource gathering tasks may suffer. Some of the women in our study talked about such disadvantages related to caring for a sick spouse or adult child.

Pearl, a 74 year old widow, said:

...the disadvantage is this, you always work hard and you don't get a chance to do your own things. For instance, my husband fell sick during the summer season. I was supposed to go to the field and plough mealies and vegetables but I didn't because I was busy

taking care of my husband, so my heart was painful when I saw other women harvesting food ploughed with their own hands (Pearl, Above average, Other death household).

Even though Pearl lived in an above average household, she still felt sad about missing out on the harvesting as a result of her husband who was sick during the ploughing and planting season. In the fieldsite, most households are involved in farming small plots for household use; therefore, caregivers from poor and average households are likely to lose even more when they spend time away from economic activities due to caregiving responsibilities.

Providing Medical Care for the Sick: The costs related with caregiving are not just those related to time. In addition, caregiving can be very costly financially. These demands may have a particularly dire economic impact on elderly women, like those in our study. These women are likely to use their pensions, which are meant for their own subsistence, to meet caregiving demands. Sickness, especially a long-term one like HIV/AIDS, increases household expenditures on medical care and food. When children need to be fostered due to illness or orphaned children are left behind, the situation perpetuates. Therefore adult sickness and death, especially when caused by HIV/AIDS, is likely to have financial impact on a household, *and* on elderly women who are using their pensions to mediate the household's costs.

Many of the respondents, in this study, reported that they used their pensions to cover some of the expenses incurred by sick family members for whom they cared. Many of our respondents believe in both traditional *and* modern ideologies about disease causation and treatment (McDonald & Schatz, 2006); therefore, they often opt for multiple treatments. Nyeleti, a 61 year old widow, explained, “Hiii.... I used a lot of money when my son who died was sick. I took him to different *sangomas* [traditional healers], hospitals and bought medicine from the

pharmacy (Nyeleti, Below average, Other death household). The practice of using multiple health providers, both traditional and allopathic, adds to illness related expenses.

Zodwa, whose son died of HIV/AIDS, said she used both tablets and *muti* [traditional medicines] to help her son when he came home from the city. He had also been to the hospital while in the city. Often the traditional healers are even more expensive than public health services. She related her experience, “For my son, while he was at home, I did use my money by paying a sangoma to give him *muti*. For the *sangoma*, I spent R500. After his arrival at home, I stayed with him for only one week before he passed away” (Zodwa, Below average, HIV/AIDS household).

Paying for Mourning & Funerals: The expenses related to illness are compounded when the family member dies. Some of our respondents said they spent a lot of money when a loved one for whom they had cared died. Mumsy, a 73 year old widow shared her experience:

During [his] sickness we suffered, because we used [all] the money we had and [also] went to our neighbors to borrow money to take the sick person to a doctor. [After he died] it was difficult because people were coming [to our home to mourn for him]. They wanted food to eat. You must spend money to buy food for them. When some people come to sleep [at your home], they don't have soap and Vaseline, so you must also give them. [On] the day of the funeral you must slaughter cattle. If you don't have, you must buy a lot of meat so that they eat after the funeral. ... I cannot remember the exact amount I spent, but [I think it is] approximately SAR5000. (Mumsy, Average, Other death household)

When there is a funeral in a household, community members often donate a small amount of money to help the bereaved. Even with this assistance, our respondents still had to take care of

most of funeral-related expenses themselves. Zodwa explained, “I bought a coffin for SAR1100. I got SAR600 from the community, and then I borrowed SAR500 to balance the payment....I think [I spent] approximately SAR5000 [for all the expenses]” (Zodwa, Below average, HIV/AIDS household). These expenses are extensive and beyond what our respondents’ (monthly) pensions can pay for.

Providing Support to Fostered Children and Orphans: In addition to taking care of the expenses incurred by the sickness and death of family members, many of our respondents also used their pensions to support fostered and orphaned children who live in their household or elsewhere. They support their grandchildren by paying their school funds, and buying clothes, shoes, as well as food. Sister, a 67 year old widow, supports the children of her two deceased sons, one of whom died of HIV/AIDS. When asked how she uses her money, she said, “I buy *mealie-meal* [maize meal], electricity, groceries and pay school fund for my children and grandchildren” (Sister, Below average, HIV/AIDS household). These narratives exhibit further expenses that older women bear when their adult children die.

Emily, who supports three grandchildren, was able to tell us the exact amount she spent on them. The father of one the grandchildren had committed suicide. When asked how much she spent last month, she replied, “I spent SAR300 for *mielie-meal* and sugar, SAR200 to buy uniform and SAR200 for school fund” (Emily, Below average, No death household). In order words, Emily spent SAR700 on caregiving for orphaned and fostered grandchildren in one month, nearly her entire pension, highlighting the importance of caregiving by grandmothers. These grandmothers took on these responsibilities partly because they believed that their grandchildren would in turn take care of them as they aged (Schatz, *in press*); however, our

respondents still complained about the financial constraints and confessed that caregiving of fostered and orphaned children is difficult.

Thandazile, who supports five grandchildren after two of her children died (one of HIV/AIDS), explained that because she's helping her grandchildren she could not use her money as she had wished, "I was supposed to build a house to accommodate my grandchildren" (Thandazile, Average, HIV/AIDS household). In addition to a house, a few of our respondents said they would have bought household utensils such as a stove, bed, wardrobe, or radio; some wanted to buy livestock. Daphney, a 71 year old widow, who supports five grandchildren, was one of those that wanted to use her pension to make improvements to her home and also pay the debt she owed for her daughter's education, "I was supposed to renovate my house, to buy a fence and put it around my compound to prevent the cattle and goats from entering my compound. Also [I wanted] to pay back the money I borrowed to pay for my daughter while she was schooling at Hoxani College of Education (Daphney, Below average, Other death household). Instead she uses her pension grant for household needs. She explained:

When I withdraw the money [from the bank], I pay the man who looks after my cattle. I pay him R300 per month. [Afterward] I buy an 80kg bag of *mealie-meal*, [bathing] soap, washing powder soap, electricity and groceries for the household. If you look at what I have listed, will there be any leftovers? You see, my daughter, R740 is too little to settle my needs (Daphney, Below average, Other death household).

Daphney prioritized the care of her family and household over her own needs, as was true for many of our respondents. She complained, however, that the pension she received each month was not sufficient to cover her family's needs.

Opportunity Costs of Caregiving: For our respondents, the time and financial burdens of caregiving mean a reduction in time spent on economic activities such as farming and trading, and using pensions for others' needs before their own. Reallocating time that would have been spent on farming or trading may result in the loss of income or food that could have helped to sustain their households during crises. Similarly, providing care to ill adult children, as well as fostered and orphaned children means spending pensions on medical care, food and clothing for others, rather than on themselves.

Our respondents' narratives also show that because of caregiving responsibilities, older women forgo some necessities that may improve their standard of living, for example, living in a modern or renovated house. Nearly of our respondents reported that under different circumstances they would have used their pensions to build or repair a house. Most of the women in our study live in houses built with mud and thatched roofs, which means there is need for them to renovate from time to time, in order to keep them from collapsing. Ethel, who had a son-in-law that died of HIV/AIDS and supports two grandchildren, expressed her fear "I was supposed to build a house because my house is cracked and it can fall at anytime" (Ethel, Average, No death household). Like Daphney and many of our other respondents, Ethel uses her pension money for household needs. The opportunity costs of caregiving for ill adult children, fostered and orphaned children include both losing time and energy that would usually be spent on economic or sustenance building activities, and can make life difficult by sacrificing better living conditions to spend money on grandchildren's care instead.

Recovering from Economic Shocks

Financial recovery from a crisis such as adult illness and death can be assisted by a regular income. Despite having a regular income from their pensions, of our 28 respondents who

reported having experienced financial difficulties related to the sickness and death of a loved one, the majority said that their households had not yet reached the socioeconomic status they had before the incident. For the 28 households that had experienced an economic shock due to an illness or death of kin, Table 2 shows the 2004 wealth ranking and each household's level of recovery.

Table 2 about here

Over half of the respondents (16 of 28) said they had not fully recovered at the time they were interviewed. Ten of these respondents were from HIV/AIDS or other death stratum while six were from no death stratum. Eight of these respondents' households were categorized as below average while four households were in the average category and four households were in the above average category.

Constance, a 69 year old widow, was one of our respondents whose household had not fully recovered financially from her daughter's sickness. Her household was ranked as "average" in 2004. Constance is also an example of a 'No death household' that was very much impacted by illness and death. Constance's daughter was sick for a long time and Constance moved into her daughter's household to take care of her for one and a half years. Her daughter passed away recently and Constance returned to her own household. At the time of the interview, Constance was caring for three grandchildren left orphaned by her daughter's death. When asked whether her own household had recovered financially, Constance replied, "Not yet, we have not recovered up till now" (Constance, Average, No death household).

Seven of the respondents who lived in households categorized as below average, said they recovered as a result of the monthly pension grant they received, while only one respondent from an average household recovered because of her pension. Mumsy, who above related all of

the expenses related to her son's illness and funeral, including having to borrow money from neighbors and pay for relatives' food and accommodation during the mourning period, said that in the time since her son's death her family has been able to recover financially with the help of her pension, "Now I have recovered because the money I'm getting for pension helps me" (Mumsy, Average, HIV/AIDS household).

Four additional respondents, who had recovered financially, gave credit to assistance from their children and burial societies rather than their pension. Burial societies are a type of insurance many of our respondents purchased monthly for future funeral expenses of family members. Goodness was among those with other sources of assistance; she said, "I don't have a problem. [I] did recover because my children helped me with money for the death and funeral" (Goodness, Above average, Other death household). Her household's ability to recover may relate to income generation by other household members; such additional income sources likely also contributed to our interviewers categorizing this household and two others in this category as above average. On the other hand, half of those that had not recovered were from below average households; lack of recovery from an economic shock likely contributed to the classification of these households as below average.

Lingering Debts: Lingering debts, incurred as a result of adult sickness and death in households, was one of the reasons why our respondents found it difficult to recover financially. Grace, a 62 year old widow, said she was still, twelve years later, struggling to pay the interest on money she borrowed from a money lender when her husband was sick and later died in 1992. She explained, "I used all of my money when my husband was sick. I took him to the hospital and also to the *sangoma* [traditional healer], where they needed a lot of money. I went to my friends and borrowed [some] money.... [For the funeral] I bought a cow, groceries and fed the people who

dug the grave. It was so difficult [for me] that I ended up going to the *mashonisa* [money lender]" (Grace, Average, No death household). In addition to the problem of lingering debt from her husband's death, at the time of our interviews, Grace had started taking care of an HIV-positive son who recently came back from the city.

For Emily, the debt she owed was due to the some expenses she incurred when her daughter was sick. Emily took her daughter to the hospital, bought her food, and had to pay for transport to visit her daughter at the hospital. She eventually borrowed some money in order to keep taking care of her daughter, who later recovered. When asked about financial recovery after her daughter's illness, Emily testified to the fact that lingering debts can sometimes hinder a household from recovering. She said, "It's difficult, my daughter, I didn't recover. I still owe people the money I had borrowed" (Emily, Below average, No death household). Lingering debts may therefore prevent households from recovering from the financial impact of adult morbidity and mortality long after they occur. Such circumstances are likely to become worse as more households are impacted by lingering illnesses related to HIV/AIDS.

Living on Credit: In addition to borrowing money, buying on credit is another coping strategy adopted by respondents. In order to manage the economic demands of caregiving, a number of our respondents live on credit. These respondents buy foodstuffs and other basic items on credit from local stores and pay for them when they get their pensions at the end of the month. Mumsy is one of the respondents that lives on credit. She said, "I buy soup, *mealie-mealie*, etc from the shop on credit and pay when I receive my money" (Mumsy, Average, Other death household).

Credit as a coping strategy is a way of life for some of these women. Every month, most of their pensions go towards paying for items bought on credit. For instance, Rebecca said, "I have an account in the shop. [During the month] I take what I want without paying and after

receiving my pension, I go to the shop and pay” (Rebecca, Below average, Other death household). This means her pension is used perpetually for paying off her debt. Despite the advantage of being able to obtain goods as the month goes on, a privilege that seems largely reserved for those with access to grants or another reliable source of income, the need to pay off these debts each month means that our respondents often have no cash remaining for emergencies. Like many of our respondents, Nyeleti uses credit and after buying items such as electricity and firewood and paying off her previous month’s credits. There is usually no leftover cash from her pension. When she was asked what she would do if one of her family members fell ill, she replied “I just go to my neighbors to borrow money to take him/her to hospital and then pay them after pay day” (Nyeleti, Below average, Other death household). Living on credit, like borrowing from neighbors or money lenders, can make older women caregivers vulnerable to financial hardship.

Selling of Assets: Selling of assets is one of the coping strategies sometimes adopted by an individual or a household experiencing a crisis, such as an adult sickness and death. Assets are sold to access cash to pay for health or funeral related expenses. Like opportunity costs discussed above, the selling of household assets like chicken, cows, or furniture disadvantages the household into the future. A few of our respondents had sold assets to cover the costs of their children’s funerals. Thandazile, whose son died of HIV/AIDS, was one of the respondents that adopted this coping strategy: “My husband sold a cow during the death of my son in order to get money to buy a coffin. [He sold the cow for] SAR1500” (Thandazile, Average, HIV/AIDS household). In some cases, instead of selling a cow, a few of the women slaughtered a cow they owned for the funeral. For instance, Auphrey said she never sold any assets but admitted she slaughtered one cow for funeral. She said, “We never bought [a cow]. We took one from our

corral and slaughtered it [for the funeral]” (Auphrey, Above Average, HIV/AIDS death household). Although using family assets can reduce the funeral costs, slaughtering a cow still decreased the family’s wealth. In this community, a cow symbolizes status, as well as representing a considerable amount of wealth.

Some of our respondents had to combine the two above strategies: selling and using household assets. In addition to slaughtering a cow for her daughter’s funeral, Sinah sold a cow to get money after the funeral. “Yes, I sold a cow in order to get money. After the funeral we did not have [enough] money to buy food” (Sinah, Above average, HIV/AIDS household). Adult mortality and morbidity impact households not only during the sickness and death but they linger on even afterwards. And as a result of this, households may sell and use their assets to cope with the lingering debt.

CONCLUSION

The findings from this study show how the sickness and death of a family member, whether due to HIV/AIDS or another cause, has an impact on the socioeconomic well-being of older women and their households. We found that when there is an illness in the family, older women take over the responsibility of giving care to the sick and the children of the sick. As they take over the physical aspect of caregiving, they also take over financial responsibilities, that is, expenses incurred by those for whom they care. As caregivers, when their patient dies, they are also responsible for mourning and burial expenses and taking care of orphans left behind. As the expenses they incur approach or are beyond the amount of their monthly pension, our respondents and their households become vulnerable to financial hardship.

Regardless of whether respondents are wealth ranking, they all feel the financial impact of caregiving. One impact of caregiving is the forgone opportunity of older women's to participate in economic activities such as farming and trading, which could positively contribute to their standard of living. Another missed opportunity is that of renovating or building a modern house, which is almost impossible to do when the costs of caregiving take precedence. In other words, these women find their own needs unmet as a result of obligations to take care of adult children who are sick or dying, as well as fostered and orphaned children. Rather than disappearing upon the death of a child, the burdens continue, sometimes long after the incident has occurred. Most of these women find it difficult to recover because they continue to owe money to neighbors or money lenders, have sold off assets to pay for funerals, or use their pensions to pay off last month's credit. Although many of these strategies keep older women and their families afloat, they also contribute to the lingering socioeconomic impact of adult morbidity and mortality.

As illustrated in this paper, there is a very real socioeconomic impact of adult morbidity and mortality on households in which our elderly respondents live. These impacts are expected to have major effects on household livelihoods (Hunter & Twine, 2005). Since the Agincourt Unit study site is a demographic surveillance system that annually collects data on households, the study site can follow prospectively households after they experience an adult illness or death. Indicators could be collected to assess how household livelihoods, as well as the livelihood of particular family members, are impacted.

The literature, and our data, show that older women are likely to be primary caregivers of adult HIV-positive children. As AIDS continues its foothold as one of the leading causes of adult mortality, there is need to ensure that older caregivers, who in more and more cases are the only

ones left to do the job, are not overburdened and left with lingering debts. Without assistance, these burdens and debts may endanger the well-being of the elderly and those in their care. When asked what the government can do to assist them, our respondents replied, “The government should build a house for me and my grandchildren.” Their desire for houses for themselves and their grandchildren shows that assistance and intervention programs for these caregivers likely will improve the well-being of their household members such as grandchildren, as well as their own socioeconomic status.

The implication of these findings is that poverty reduction and HIV/AIDS programs need to target older people, particularly older women who are more likely to be caregivers. There is also a need for such programs to recognize the extent of older persons’ obligations, and the extension of their obligations beyond their households. The current non-contributory pension program is targeted at older people in order to reduce or eradicate poverty among them, but its purpose is being undermined by crises such as adult morbidity and mortality and morbidity in their households and beyond. By creating specific poverty reduction and HIV/AIDS programs targeted at elderly caregivers, these programs might go beyond reducing the financial burden of caregiving to helping elderly caregivers provide better care for those they assist. As emphasis shifts to home-based care for HIV-positive individuals, more support is necessary for elderly household members put in the situation of taking care of their kin.

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Table 1: 2004 Household Wealth Ranking by Mortality Experience

| | Below Average | Average | Above Average ^a |
|-----------------------|------------------|---------|-------------------------------|
| HIV/AIDS Household | 7 | 1 | 2 |
| Other Death Household | 4 | 2 | 4 |
| No Death Household | 4 | 3 | 3 |
| Total (N=30) | 15 | 6 | 9 |

^a Since all the respondents are poor enough to qualify for the means-tested pension grant, the scale 'below average' to 'above average' is used here to rank households by their comparable socioeconomic status in this rural context.

Table 2: Household's wealth ranking by level of recovery from expenses related to illness/death of kin

| | Recovered due to pension | Recovered due to assistance | Partial/No Recovery |
|---------------|--------------------------|-----------------------------|---------------------|
| Below Average | 7 | 0 | 8 |
| Average | 1 | 1 | 4 |
| Above Average | 0 | 3 | 4 |
| Total (N=28) | 8 | 4 | 16 |