

HIV/AIDS AND POVERTY IN HOUSEHOLDS
WITH CHILDREN SUFFERING FROM
MALNUTRITION:
THE ROLE OF SOCIAL SECURITY IN MOUNT
FRERE¹

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THE MOUNT FRERE AREA in the Eastern Cape suffers one of the highest rates of child malnutrition in South Africa as well as one of the poorest take-up rates for the Child Support Grant. This case study explores how HIV/AIDS and other long-term chronic illnesses together with extreme poverty affect households with children suffering from severe malnutrition. It examines the role of social security in supporting or failing to support these households as they cope with the impact of HIV/AIDS.

Concentrating on households with children hospitalised for

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¹ This paper is part of the more comprehensive research report "Social Security Transfers, Poverty and Chronic Illness in the Eastern Cape." This report was published on 21 May 2002 by the Economic Policy Research Institute (EPRI). The project was carried out by EPRI and Oxford University's Social Disadvantage Research Centre (SDRC). The University of the Western Cape's School of Public Health (SPH) carried out the field research. The project leader was Robert van Niekerk (SDRC). Other members of the team included: Michael Noble (SDRC), Maria Sigala (SDRC), Nonzwakazi Sogaula (SPH), David Sanders (SPH), Debra Jackson (SPH), Kenneth Mac Quene (EPRI), Michael Samson (EPRI), Ingrid van Niekerk (EPRI), Carolyn Green (EPRI) and Allison Stevens (EPRI).

severe malnutrition purposively focuses (and biases) the study towards the poorest households in the country, particularly in the context of the study's location in Mount Frere. Child malnutrition is highly correlated with paediatric AIDS, which in turn is highly correlated with the presence of other HIV/AIDS-infected individuals in the household. Some of the most severe consequences of the HIV/AIDS pandemic are evident in these households. This paper analyses the link between HIV/AIDS and malnutrition, assessing the role of poverty and the mitigating impact of the social security system.

1. HIV/AIDS AND CHILD MALNUTRITION

The Kagera household impact study identifies how the presence of HIV in the household raises the likelihood of exposure to other infections, which in turn, raises the risk of malnutrition for young family members. "Morbidity and malnutrition," states Ainsworth and Semali (2000:6, 10) "have a synergistic relationship. Illnesses such as tuberculosis, diarrhoea, and measles, have well-documented biological effects on worsening children's nutritional status, while severely malnourished children have higher morbidity and mortality." Malnutrition in and of itself can cause immuno-suppression in young children by inhibiting host defences, impairing tissue repair functions, and compromising the body's ability to resolve attacks of acute diarrhoea (Thea *et al.*, 1993). It is therefore difficult, even with HIV-positive infants, to distinguish whether the cause of increased immuno-suppression is the virus or the resulting malnutrition. "In either event," states Thea *et al.* (1993:1701), "the cyclic effects of diarrhoea, malnutrition, and immune dysfunction can produce an accelerated downward course" for infected infants with persistent diarrhoea.

Some medical studies, such as that conducted by Taha *et al.* (1995:1027) in urban Malawi, indicate that "maternal HIV infection is the main determinant of mortality in the first 30

months of life.” The mortality rate of children born to HIV-infected mothers in this study was 3 times higher than those born to sero-negative mothers (36 per cent as compared with 12 per cent), even though many of these infants had normal birth weights. Children born to sero-negative mothers had a higher probability of survival over their first 30 months while children born to sero-positive mothers were more likely to die from pneumonia, fever, failure to thrive and diarrhoea (Taha, 1995:1024).

Meyers *et al.* (2000:224-226) assessed both the HIV and nutritional status of 92 per cent of all children under the age of five admitted to the Chris Hani Baragwanath Hospital (CHB) in Soweto, South Africa from June to December of 1997 (507 of 549 admitted). The study found an HIV prevalence of 22.9 per cent. Of the 507 children tested, 66.9 per cent of the uninfected children were well nourished compared to only 34.3 per cent of the children who were HIV positive. A total of 29.4 per cent of the infected children had marasmus (emaciation) or marasmus-kwashiorkor (protein-energy malnutrition with oedema) as compared with 4.7 per cent of the uninfected children. Without citing diarrhoea as a factor, this study noted that “infectious disease and associated malnutrition were the most common reasons for admission in HIV infected children.” At the time of death, 76 per cent of the infected children who died were malnourished and over 50 per cent were severely malnourished. Of those who died uninfected with HIV, 53 per cent were nutritionally compromised but only two were severely malnourished (Meyers *et al.*, 2000:228).

Bailey *et al.* (1999:537), in a study of over 500 children in the Democratic Republic of Congo, found that mothers' HIV status had a direct affect on their ability to care for their children. “In Congo,” according to Bailey’s 1999 study, “uninfected children of sero-positive mothers suffer nearly twice the incidence of persistent diarrhoea as uninfected children of sero-negative

mothers and the incidence of infant diarrhoea increases with severity of maternal disease.” Bailey *et al.* (1999) concluded that the mother’s disease led to “increased risk in their children for under-nutrition, diarrhoea, and respiratory infections that would likely retard growth progression.” The infected children also suffered significantly more stunting (low height for age), wasting (low weight for height) and under-nutrition than did their uninfected cohorts ages 0 to 18 months. Persistent diarrhoea was strongly associated with malnutrition and HIV infection in Congolese children as it was for the children in Soweto.

Persistent diarrhoea, according to Thea *et al.* (1993:1700), is likely to occur earlier in infected than in uninfected infants. In their prospective study of over 400 Zairian infants, 45 deaths occurred in infants whose HIV status was known. Of these deaths, 24 per cent were due to persistent diarrhoea and 91 per cent occurred in HIV-infected children. Diarrhoea was the leading cause of death in the cohort (36 per cent) but for HIV positive children, the mortality rate from diarrhoea increased by 11 fold. Children whose mothers were symptomatic of AIDS had higher incidence of diarrhoea though the risk of persistent diarrhoea also increased for uninfected infants whose mothers had died of AIDS (but not those whose mothers were sick). The risk of persistent diarrhoea increased for infected infants as well if the mother was either symptomatic or had died of AIDS (Thea *et al.*, 1993:1698, 1701).

Thea *et al.* (1993:1701), like Bailey *et al.* (1999), asserted that morbidity “and by implication mortality, was related to the ability of the mother to care for her infant and maintain infant hygiene and nutrition, especially during episodes of acute diarrhoea needing increased attention. Episodes of acute, recurrent, and persistent diarrhoea occurred significantly more frequently among infected infants than among uninfected controls”. The significance here lies in the fact that such

“repeated episodes of acute diarrhoea often lead to increasingly severe protein-energy malnutrition, specific micronutrient deficiency...or a combination of the two” (Thea *et al.*, 1993:1700-1701).

Even if the child is uninfected with the virus, the mother’s illness with AIDS-related infections is likely to create a situation in which the child is more susceptible to diarrhoea which in turn leads to malnutrition. This compromises the child’s ability to resolve the acute diarrhoea, increasing the child’s risk of death. If the child is also infected, her system will tend to be immuno-suppressed not only by malnutrition but by the virus as well, further raising the risk of death. Interventions that delay the morbidity and mortality of the HIV-infected mother could thus significantly contribute to the long-term survival of uninfected children of infected mothers (Thea *et al.*, 1993:1701).

Data regarding malnutrition in AIDS-affected households or AIDS-infected children must be regarded cautiously. In many of the countries cited by these studies, protein-energy malnutrition was prevalent prior to the AIDS epidemic. Nevertheless, it is clear that paediatric AIDS brings with it symptoms of weight loss and protracted diarrhoea. Failure to thrive is the most consistent symptom afflicting HIV-infected children (Kurawige *et al.*, 1993:94-95).

The literature on policy options grapples with the role of directly targeting AIDS-affected households. Over (1999:8) suggests that targeted support should be broadly based. Where equity is the concern, it is important to “target assistance efforts to the poorest orphans, regardless of the cause of their parents’ death.” Ainsworth and Semali (2000:31-32) go further, suggesting that interventions should be targeted to the poorest households. Health interventions targeted to children on the basis of a recent adult death in the household would arbitrarily exclude many children with equally severe poverty-related health problems, while expending resources on children in households

that have adequate means. Mutangadura (2000:26) argues for a broader distribution of social welfare assistance, independent of the immediate cause of poverty, and highlights the resulting improvements in child welfare, nutrition and access to education.

2. THE MOUNT FRERE CASE STUDY

(a) The Study Sample

The study sample includes a total of 30 households consists/consisting of 103 adults (37 men and 66 women) and 134 children (71 boys and 62 girls). The mean age of the adults was 36; the average age of the children was seven years. They lived in Mount Frere, part of region E of the Eastern Cape. The region is comprised of former areas of the Transkei Bantustan with two magisterial districts called Kwabacha and Tabankulu.

(b) The Demography of Poverty in the Eastern Cape

The Eastern Cape has a high prevalence of poverty, chronic illness (including those associated with HIV/AIDS), and infant and child mortality. The poverty rate in the Eastern Cape is 74.3 per cent compared to 45 per cent for South Africa as a whole. The Eastern Cape's Human Development Index of 0.596 is the second lowest in South Africa, and compares to 0.628 for the entire country (UNDP, 2000). The Eastern Cape also has South Africa's highest infant mortality rate, numbering 55 of every 1000 live births compared to a national average of 41 per 1000 (DSD, 2000:73). This underdevelopment is linked to the high proportion of the population living in rural areas - 63.4 per cent of the population live in non-urban areas (DSD, 2000:73).

Only 22 per cent of households in the Eastern Cape have access to safe water from an internal household tap compared to (an itself very low) South African average of 40 per cent. Only 30 per cent of households receive electricity direct from

the authority, the lowest in the country and compared to a national average of 55 per cent. The use of paraffin as an alternative heating source constitutes 37 per cent of the total, again the highest use of such a heating source in the country. Only 31 per cent of households have refuse removed weekly by the local authority with 23 per cent of households registering no refuse disposal compared to a South African average of 11 per cent (DSD, 2000).

The broader population is dispersed across the rural areas, with no defined centre and thus the inaccessibility of transport has a dramatic effect on the ability of users to access government services. The Eastern Cape has the highest rate of unemployment in the country at 48.5 per cent with only 50.8 per cent of males and 49.2 per cent of females being economically active (DSD, 2000). This high rate of unemployment makes households heavily dependent on remittances and government support through social security.

(c) Sample Selection

The 30 households in the sample were selected from households with a child with severe malnutrition admitted to either Mary Terese or Sipetu hospitals in the Mount Frere Health District (Mount Frere and Ntabankulu Sub-Districts). These children were accompanied by their parents for the duration of their hospital stay and it was during this time that consent was obtained from the parents for recruitment into the study.

A total of 43 households were recruited and 30 were successfully contacted. 26 of the households were recruited from Sipetu hospital (Ntabankulu sub-district), which is consistent with higher rates of malnutrition recorded in this sub-district. The field researcher conducted home visits to each household between the months of September and December 2001.

(d) The Interview Process

The structured questionnaire was developed drawing on national and international research examining income and expenditure patterns of households affected by chronic illness, including HIV/AIDS. The interview style was developed to elicit a narrative on household circumstances, using a structured questionnaire. (In order to illuminate the following analysis, quotations from the interview narratives are included in text boxes in relevant sections below.) All households were visited by the same field researcher, who conducted the interview in Xhosa. Data were obtained both at an individual level and a household level. Individual cases contained data on the adult and child population in each household as well as information on remitters and remitees in these households. Household data contained information on household assets and expenses as well as details about the status of the household regarding social security benefits.

(e) Descriptive Findings

Thirty-four boys and 30 girls attended school, and over half participated in school feeding schemes. Twelve children received food at school twice a week, five thrice a week and four children received food four to five days a week. Ten girls and three boys in eight households had stopped schooling, the most common reason being the lack of money to pay for school fees and uniform.

Thirteen young adults (six males and seven females) aged 19 to 24 attended schools. Only four of these young adults received any food at school. In all but one household at least one adult had completed some schooling and in 18 of the households at least one member had finished high school.

One household head provides for her family by selling firewood for R12 a bunch, sometimes earning R36 per week. The trip to the forest takes five

exhausting hours. However, when it rains or the children are sick, she cannot go to the forest to gather wood, and her income is zero. During the dry season she also makes mud bricks. During an entire season she makes about 100 bricks, which she sells for 90 cents each.

The majority of the adult household members described themselves as unemployed. Sixty-three adults described themselves as unemployed in comparison to 39 who were engaged in some form of informal, episodic or temporary employment. All but three households had adults who were unemployed at the time of the survey. Few of those who were doing some form of paid work worked steadily throughout the year. Most were self-employed selling wood, thatching grass and/or mud bricks, and 62 per cent of self-employed people earned a monthly amount of only R50 to R100. Only eight adults worked as permanent full-time employees, with three part-time and two in temporary employment. The highest paid workers earned R448 per month. Households primarily relied on remittances and social security grants.

Nineteen households reported incidence of severe chronic illness in the past year, affecting 15 adults and 22 children. In 11 households, illness symptoms were indicative of HIV/AIDS. The duration of the chronic illnesses reported was between six months and 10 years. For the majority of the adults, illness had lasted between one and four years. The members, on average, took medication for approximately two years. The 30 households reported 11 deceased adults, of whom six were men and five were women. Of the six cases where the age was disclosed, one was aged 89, the others below pension age, that is, two in their twenties, two in their thirties and one aged 40. In addition, the households reported 18 infant and child deaths, of which nine were attributed to malnutrition and/or diarrhoea.

"The only chair in the house is a school chair. The table is also a school table. An empty bottle crate is used as a second chair. There is one single

bed in the house. A pile of ragged blankets is lying on the corner as there is no wardrobe. The blankets are used by a child for sleeping.”

Mean household spending on food in the sample was R279 per month, with an additional R67 per month on non-food expenditure. Households reporting no chronic illness spent more on food than those with chronic illness, particularly chronic illness consistent with HIV/AIDS. Twenty-three households had annual expenses related to schooling, the highest of which was for uniforms for school children, with a mean annual cost of R118. No household owned a telephone, but nine owned a radio. Twenty-seven households owned livestock, at least one bed and a table. Most households owned land that they utilised. Over the past year 12 households had sold livestock (four of them to cover educational expenses), one household had sold a bed and another had sold a wardrobe - both to cover educational expenses. Only one household was living in a house made of brick; 28 houses were made of mud. 16 households used a river or dam for drinking water and ten used a communal tap.

The husband of one household head worked as a miner but was dismissed in 1983 because of partial deafness. He received hospital treatment but never regained his full sense of hearing. He was classified as disabled and was able to claim a Disability Grant in 1985. In March 2001, the grant was terminated, and he was given the official reason that there had been “changes in policies and regulations”. The Department of Social Development advised him to apply for a State Old Age Grant, and he made a claim in June 2001. However, during the 6 months that elapsed before he began to receive the grant in December 2001, the household relied on an inadequate R100 per month sent by a relative who also worked in mining. The household was unable to provide an adequate level of food—one child was sent to live with relatives and the youngest child was subsequently admitted to the hospital for malnutrition. He fell ill again as soon as he was discharged.

Although all 30 households had members who were eligible for a social security grant, only 16 households actually received any kind of social security grant. Most of the households with members eligible for Old Age Grants were claiming them and half of the households with members eligible for a Disability Grant received it. However, the take up rate for social security grants targeting children was very low. In particular, the take up rate for the Child Support Grant was only 7 per cent. There were only four children for whom the grant was received out of a potentially eligible population of 54. Three of the children who were not eligible for the Child Support Grant were self-employed selling wood, grass thatching and/or mud bricks, making between R50 and R100 per month. Of the 17 households with members who met the eligibility criteria for the Foster Care Grant, none were receiving it.

3. EMPIRICAL FINDINGS

While the study's sample size did not support in-depth multivariate statistical analysis, simpler comparisons did illuminate a number of important hypotheses for further research in subsequent stages of the programme. The analysis investigated the income, expenditure and investment patterns of the households and examined in particular the impact of social security and household health status on these patterns. Households were divided into those that had succeeded in qualifying for and actually receiving a social grant, and those that had not. The survey instrument included detailed eligibility criteria for each social grant, enabling the research team to determine grant eligibility for each person in the sample. In addition, three categories of health status were identified: (i) those households with at least one member reporting combinations of symptoms indicative of HIV/AIDS², (ii)

² Symptoms of HIV/AIDS in this study included tuberculosis, body

households with no members reporting symptoms of HIV/AIDS but indicating another long term chronic illness or ailment, and (iii) households with no members reporting major health problems. Unless otherwise noted, all tests of significance used a two-tailed t-test with a five per cent significance level.

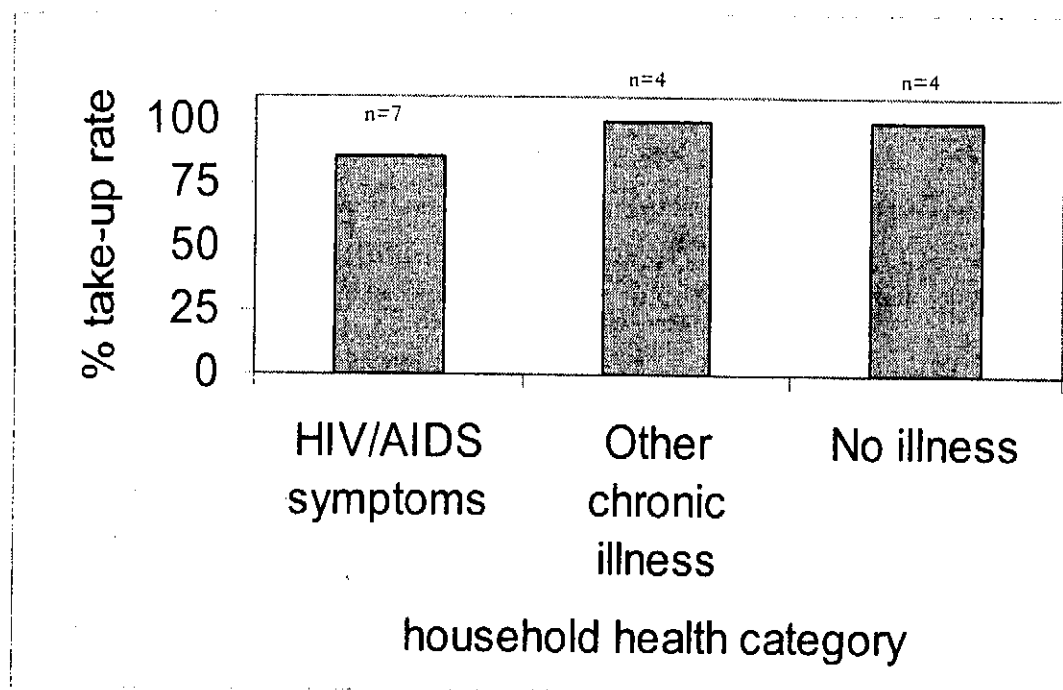


Figure 1. State Old Aged Pension Take-Up Rates by Household Health Category

The main source of income for households in this sample is the State Old Aged Pension, which provides 15 pensioners with an income more than twice the average reported by the employed workers in the sample. Fig. 1 documents the take-up rates for the pension. None of the take-up rates are notably different from 100 per cent, reflecting the success of the Department of Social Development in distributing this key anti-poverty resource.

The take-up rate for the Child Support Grant, however, reflected a much more dismal situation. Only three

swelling, severe weight loss, malnutrition, loss of appetite, diarrhoea, persistent coughing, nausea and vomiting, as assessed in consultation with the medical researchers.

caregivers(caring for a total of four children) had succeeded in qualifying for and actually receiving the Child Support Grant. Fig. 2 depicts the take-up rates for the Child Support Grant by household health status.

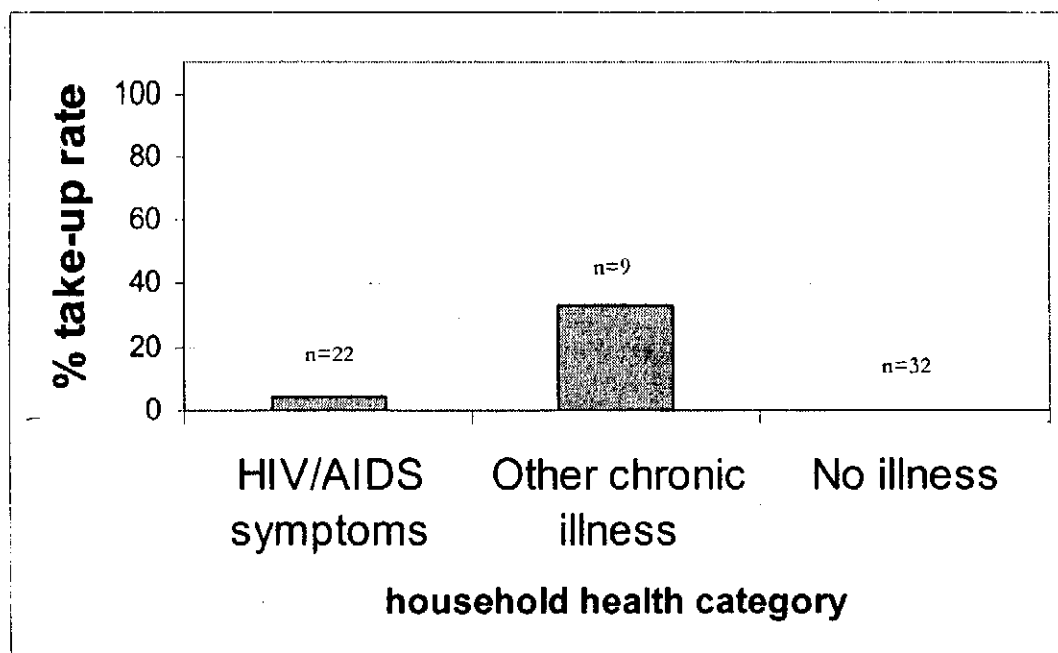


Figure 2. Child Support Grant Take-Up Rates by Household Health Category.

Surprisingly, take-up rates for children in households with members in relatively poor health were higher than in households with only healthy members. The take-up rate for households with at least one member reporting symptoms of HIV/AIDS was 5 per cent, compared to 33 per cent for households with members reporting other chronic illnesses. No child in a household with all healthy members was successful in qualifying for the Child Support Grant. However, because of the very small number of successful applicants in the sample, none of these take-up rates are significantly different from zero. The finding, however, does raise the question of whether healthier households might find it more difficult to qualify for the Child Support Grant.

One possible explanation is that households with fewer healthy members might already qualify for another social grant, such as the Disability Grant or the State Old Aged Pension

(since health generally deteriorates with age). Experience with another social grant might support the application for the Child Support Grant in a number of ways: (1) the household might be more familiar with the application process, (2) the household might possess the necessary qualification documents, (3) the caregiver might be known to the caseworkers in the Social Development office. Fig. 3 depicts the take-up rates for the Child Support Grant for two groups: (i) those children in households with some extended household experience with the Disability Grant or the State Old Aged Pension, and (ii) those households with no members having ever successfully qualified for a social grant.

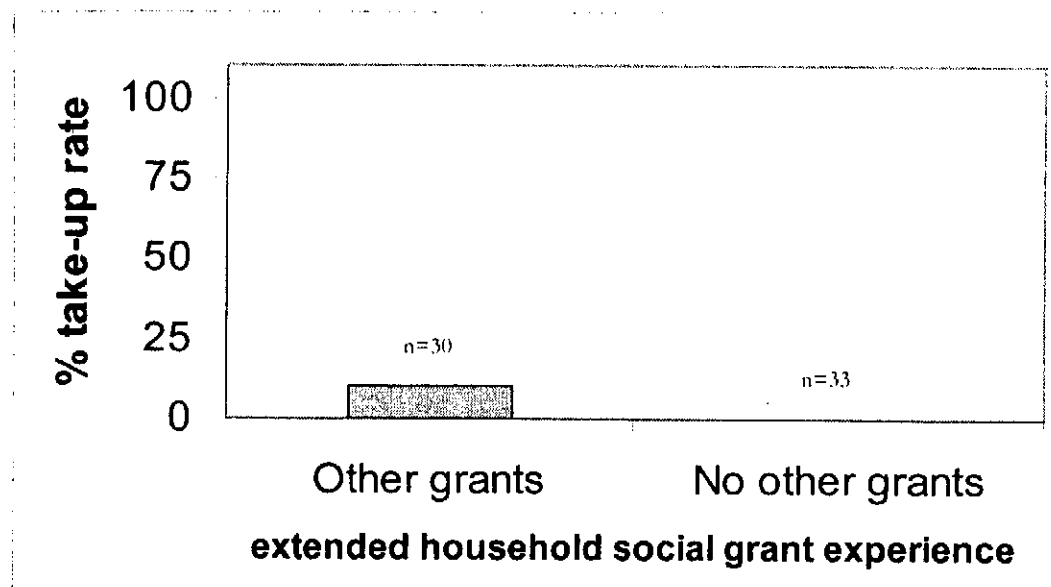


Figure 3. Child Support Grant Take-Up Rates depend on Experience with other Social Grants

The take-up rate for children in households with a successful application for another social grant was ten per cent. No successful Child Support Grant applicant was in a household with no positive experience in the extended household with a successful social grant application. The reasons cited by caregivers for failing to receive a Child Support Grant support the hypothesis of a link between positive previous experiences with social grant applications and successful qualification for a

Child Support Grant. In particular, failure to possess the necessary documents proved to be one of the most significant barriers to successful application, and one of the most time-consuming impediments to overcome.

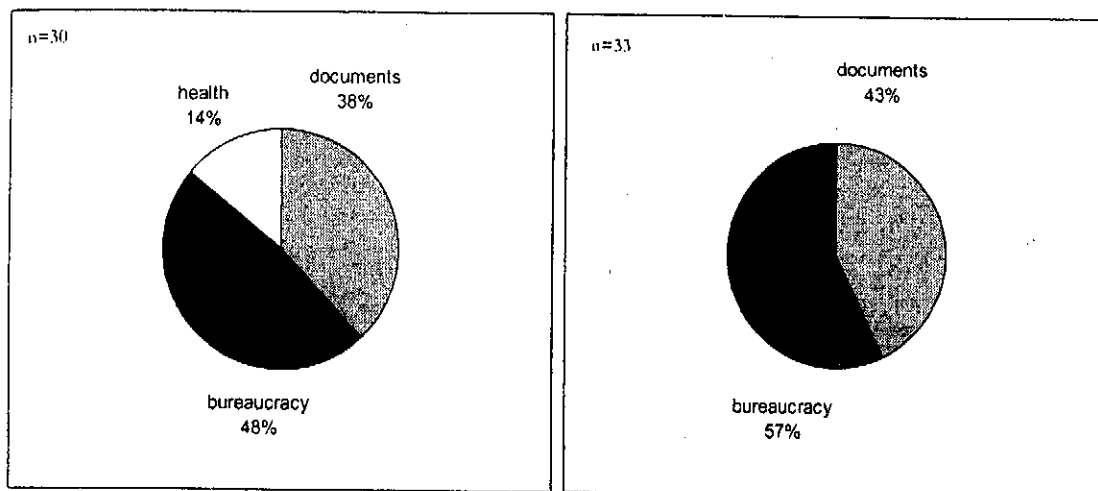
The problem with documentation was compounded by the household structure in Mount Frere. Changes in caregivers, due to poverty shocks or HIV/AIDS-related deaths, complicate the documentation required for successful application for the Child Support Grant. In addition, the learning process in successfully qualifying for a grant provides useful experience for dealing with an often uncooperative bureaucracy, another constraint frequently cited by the respondents. For instance, applicants who were required to make repeated visits to Social Development offices in order to comply with eligibility requirements for their first grant were able to qualify for a subsequent grant with a single visit.

Fig. 4 shows the relative frequency of the major reasons indicated by households for their failure to qualify for a Child Support Grant, demonstrating the differences between those households receiving other grants and those who do not.

For both groups, failure to possess the necessary documents is the single most cited explanation. In particular, lack of birth certificates, bar-coded identification documents and road-to-health cards with caregiver names consistent with the child's birth certificate were major problems. The larger category - "bureaucracy" - represents a host of administrative problems: social development caseworkers providing the wrong information, long queues, extended processing times, inefficiency and other administrative problems. While caregivers were generally well informed about the existence of the grant, there was considerable misinformation about the specific details of eligibility, a problem compounded by bureaucratic failure. The cost of transportation interacts with the "bureaucracy" problem - caregivers report that the high

cost of reaching the Social Development office combined with the need to make several trips in order to overcome bureaucratic failure undermines efforts to qualify for the grant. In addition, three caregivers cited health reasons. All three of these were in the group whose households had never qualified for any social grant - but these were spread evenly over the household health categories.

The case study provided insight into the nature of the problems with the delivery bureaucracy. For example, in 2001 the Department of Home Affairs and the Department of Social Development conducted a joint three-day outreach programme.



Households receiving no other grants

Households receiving other grants

Figure 4. Major Reasons cited by Households for failure to receive Child Support Grants

Home Affairs facilitated the obtaining of the required birth certificates while Social Development accepted applications for the Child Support Grant. In one household in the study, the father of two children was able to obtain birth certificates on the second day of the outreach programme. However, on the third day, while he waited in a queue to apply for the Child Support Grant, the outreach programme team wrapped up their work. The household had not received the grants at the time of this study's interview.

In another household in the study, the grandmother of

seven children (all under the age of seven) attempted to apply as caregiver for their Child Support Grants. Again long queues and the short duration of the outreach programme precluded her successful application. In a third household in the study, the head of household could not even obtain the necessary identification documents. She was told to bring a relative to verify her identity. However she had no relatives who lived nearby and she could not afford to send for those living a far distance away.

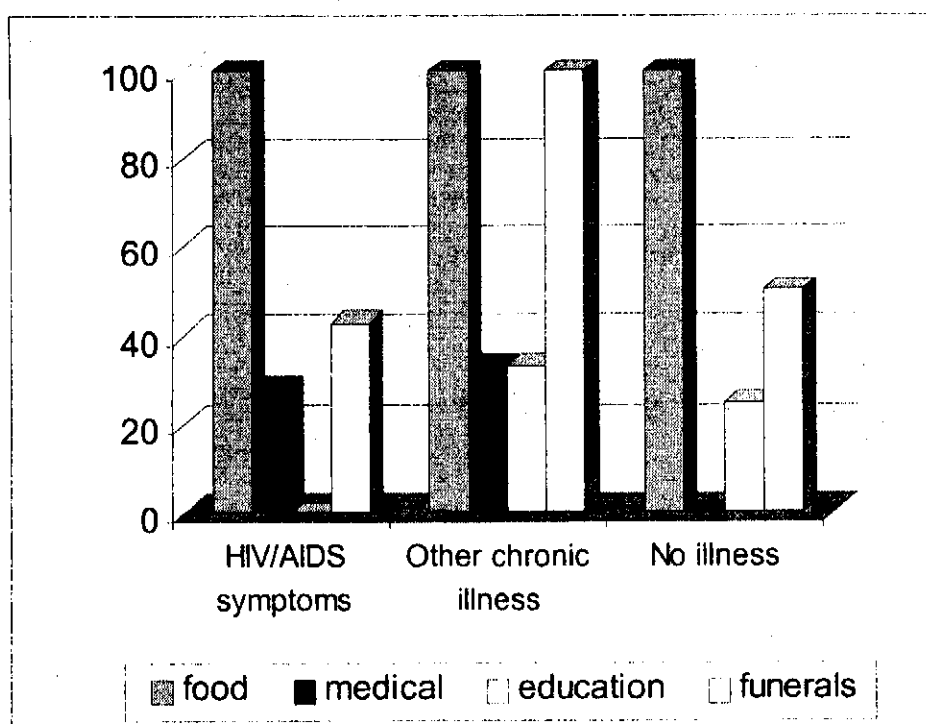


Figure 5. Percentage of households that increase spending on indicated items after receiving a social grant (households could indicate more than one expense category).

Households who succeeded in receiving a social grant demonstrated significant consistency in reporting how the resources were spent. All households reported spending some of the increased income on food. Households with members reporting HIV/AIDS symptoms or other chronic illnesses also indicated an increase in expenditures on medical care. Some households reported spending some of the grant on educational expenses. Next to food, however, the most consistently

reported use of the additional resources was for funeral expenses.

While households reported owning a limited range of assets, particularly land, livestock, furniture and personal use items, there appeared to be no active secondary market in most of the assets. HIV/AIDS-symptomatic and healthy households were equally likely to own and utilise land, while households with other chronic illnesses were less likely to utilise their land. However, no household reported selling land in the previous year. The only asset regularly reported as sold by households was livestock. All households receiving a social grant reported owning livestock. However, only 77 per cent of the households not receiving a social grant reported ownership of livestock.

The study has highlighted the role of livestock as a savings vehicle for very poor households in the Mount Frere region. Future studies will investigate this asset more rigorously, in particular by tracking the stock of the asset over time by household. In addition, the study has identified the important role of livestock in funerals. Households preparing a funeral yet not owning adequate livestock create much of the demand satisfied by households who have animals to sell. Households selling livestock generally do so to raise money for food or school fees.

The percentage of households selling livestock varied by household health status and by social security grant status. Surprisingly, households with members reporting HIV/AIDS symptoms were least likely to report selling livestock in the previous year, and of these, the households not receiving social grants sold no livestock at all. (All of these households, however, reported owning livestock.) While these findings are not clearly statistically significant, given the small sample, the results raise important questions for future hypothesis testing.

Households with members reporting other chronic illnesses have a moderately high incidence of selling livestock over the

previous year, with these households receiving social grants relying moderately less on asset sales.

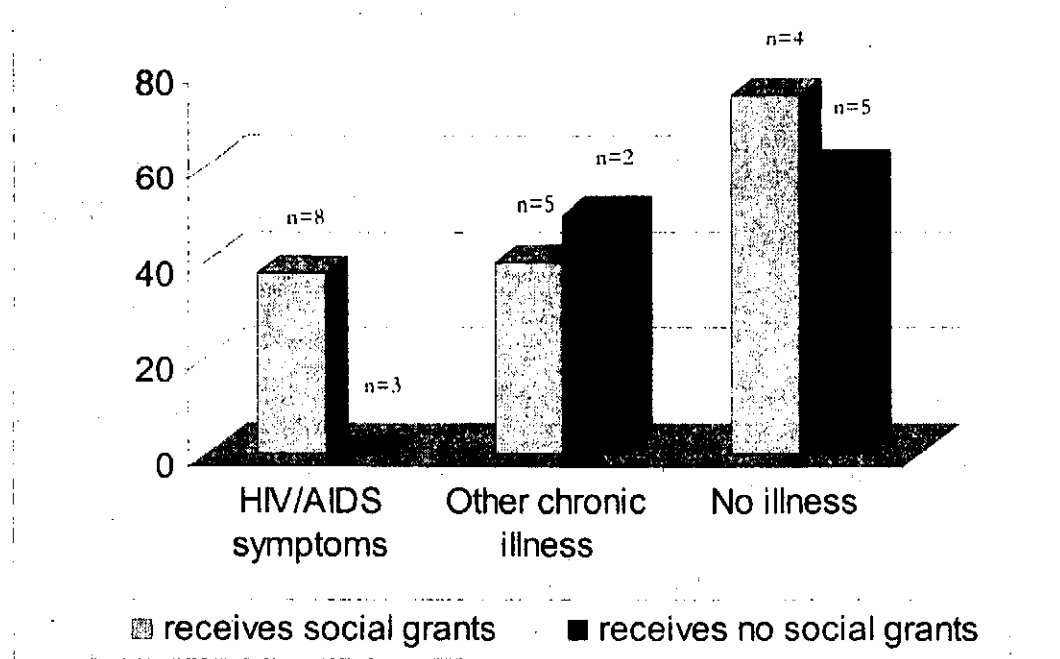


Figure 6. Percentage of Households selling Assets (Livestock) in Past Year

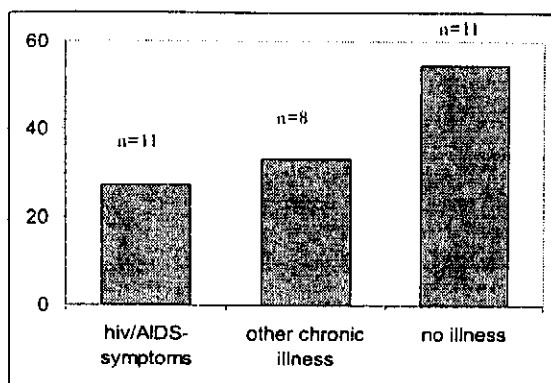
Surprisingly, households with no reported illnesses had the highest incidence of asset sales, with households receiving grants having the highest proportion of selling livestock. One apparent explanation for this is the frequency with which livestock is sold in order to finance school fees and other educational expenses. Households in which members did not report illnesses have a larger population of school-aged children, and educational expenses account for 50 per cent of livestock sales in these households compared to only 33 per cent in households reporting HIV/AIDS symptoms and other chronic illnesses.

Household health and social security status also affected the accumulation of human capital. HIV/AIDS affects schooling in a number of important ways. First, to the extent that it causes income failure, the resulting poverty reduces resources available for education. Second, by debilitating the caregiver and often reversing roles, turning the child into the caregiver, HIV/AIDS reduces opportunities and support for

education.

This study did not find a strong direct link between household health status and educational outcomes. A lower percentage of households with members reporting HIV/AIDS symptoms included children who dropped out of school. However, this difference disappears when adjusting for the fewer number of children in HIV/AIDS-affected households.

By household health category



By social grant category

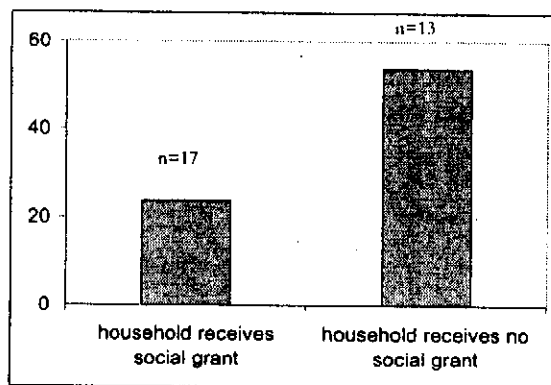


Figure 7. Percentage of Households with School-Aged Children leaving School.

The analysis raises a number of issues for future investigation. Is much of the impact of HIV/AIDS on educational attainment hidden by indirect effects? For instance, if HIV/AIDS-affected households send their school-aged children to other households for care, then subsequent school-leaving might not be attributed to the HIV/AIDS shock. The school-leaving will be associated with a healthy household. This underscores the need to go beyond conventional household definitions in analysing the impact of the pandemic on extremely poor individuals.

The most significant determinant of school dropout rates identified in this study was the social grant status of the household. Households receiving social grants had less than half the incidence of school-aged children leaving school, even though they had a larger number of school-aged children.

School fees posed a significant barrier to children's access to education. Most of the households had grave difficulty in providing enough food to stave off daily hunger - the additional

burden of school fees was not affordable in many households. In one household, two children - aged 11 and 13 years - were still in their first year of primary school (grade one) at the time of the study, because they had been barred from attending school due to the household's inability to pay school fees. They are now self-employed selling wood to pay their school fees, and are making some progress in school. In another household in the study, the mother reported that her child could not attend school because of her inability to afford the school fees.

"People here live in poverty. The Disability Grant for one disabled individual is not only feeding that person—it is sometimes feeding seven other people. They are all depending on that money" (District Surgeon Dr. Ngcwabe, 6 August 2001).

The head of one household in the survey was the sole income earner financially responsible for nine children. Her partner's death two-and-a-half years ago intensified the household's poverty. One of the children was admitted to hospital for malnutrition and subsequently died. The household head relied on her mother, a pensioner living in another part of the village and receiving a State Old Age Pension, which she used to support the family. The pensioner died, pushing the household into severe destitution. The household head described the impact:

"Starvation is upon us. We do not have food, children go to bed without having eaten. Even last night we did not have supper. Children had to stop schooling."

In the absence of an effective and comprehensive public social safety net, individuals rely on private remittances for their survival, particularly from the recipients of social grants. This study underscored the importance of private remittances and the sharing of social grants. The study found important impacts of HIV/AIDS and social security on the private safety net in the Mount Frere region. Households with members reporting HIV/AIDS symptoms had the highest percentage receiving remittances - 73 per cent compared to 25 per cent for households with other chronic illnesses and 36 per cent for healthy households. However, there was enormous variance in

the actual size of remittances received by households across the health categories.

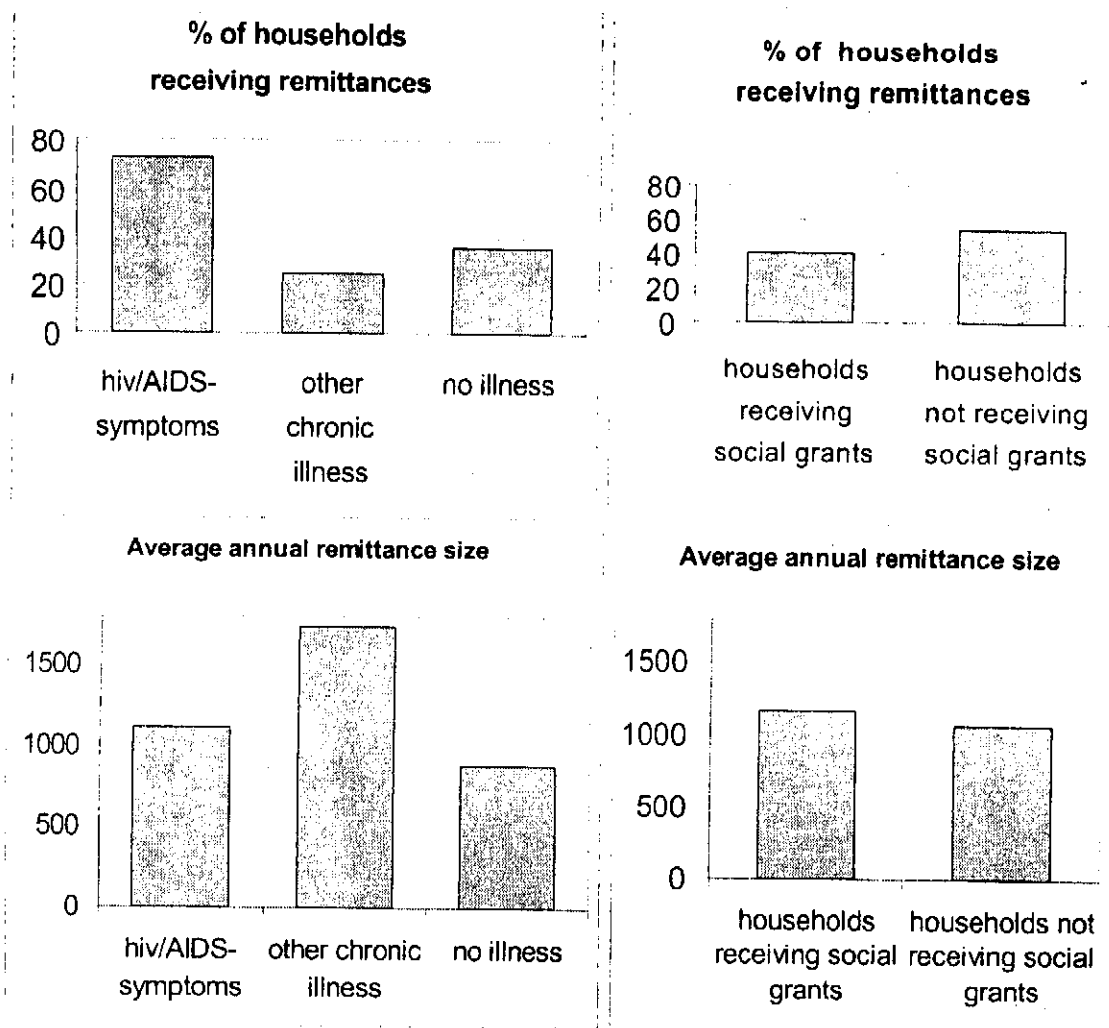


Figure 8. How does HIV / AIDS and Social Security affect the Receipt of Private Remittances?

Not surprisingly, households receiving social grants were less likely to receive private remittances than those not receiving social grants. Households receiving social grants however received a slightly larger average remittance, although this difference was not statistically significant. No evidence clearly explained the different magnitudes in the average remittance size, a problem compounded by relatively poor information in this study on the individual or household characteristics of the remitter.

Some evidence, however, was gleaned from analysing the

remitter behaviour of the thirty households in the study. Households with members reporting HIV/AIDS symptoms were least likely to contribute remittances to other households - only nine per cent of these households sent remittances. Similarly, only 25 per cent of households with other chronic illnesses provided remittances, while 57 per cent of healthy households contributed remittances.

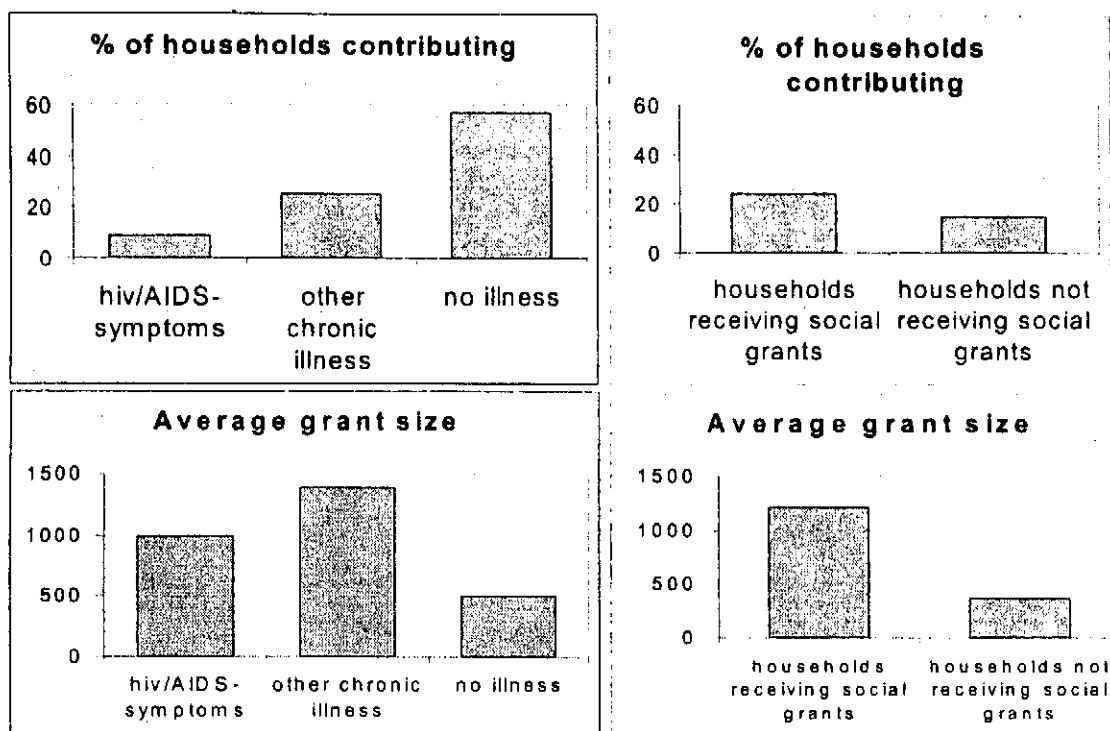


Figure 9. How does HIV / AIDS and Social Security affect the Contribution of Private Remittances?

However, household health status did not so neatly explain the size of remittances - there was substantial variance in remittance size within each of the three categories. Social grant status was a more consistent determinant of both the incidence of contributions and the average size of the remittance. Twenty-four per cent of households receiving social grants provided remittances, while only 15 per cent of households not receiving grants contributed. More significantly, the average remittance from a household receiving a social grant was R1220, while the average contribution from a household who did not receive a social grant was only R367. Future research will more completely

quantify the nature of the remittance relationships on both the remitter and remittee sides.

4. CONCLUSIONS

This article documents cases in which South Africa's system of social security proved inadequate to mitigate the economic impact of HIV/AIDS and poverty on households with children suffering from severe malnutrition. The case study evidence supports the linkages identified in the international literature. In some cases, HIV/AIDS may have increased the children's susceptibility to severe malnutrition. In addition, HIV/AIDS-infected household members who suffered income loss and possibly death in the household also experienced an inability to adequately support the children. The cost of medical care crowded out resources for food. In some cases, illness forced the relocation of children to other households.

The most consistent finding in the study is the extent to which extremely poor households depend on remittances and social security. Problems with the social security system aggravate the severe poverty afflicting the subjects of the case study. While the State Old Age Pension was fairly effective, the resources were severely stretched to support an extended family and social network. The very low rate of take-up of the Child Support Grant deprived households of the critical resources required to protect the children from severe malnutrition.

The study reinforces the findings of the Taylor Committee (2002), which identifies the critical need for building a comprehensive system of social security for South Africa.³ The study documents how targeting mechanisms, the means test

³ The Committee of Enquiry for a Comprehensive System of Social Security (commonly referred to as the Taylor Committee) has recommended the implementation of a universal income grant to all South Africans, initially to be phased in through an extension of the Child Support Grant.

and bureaucratic impediments to grant delivery undermine the effectiveness of the existing system of social protection.

In the short run, the Department of Social Development's current initiatives to extend the Child Support Grant to three million more children and to increase the size of social grants will provide some relief. In the medium term, however, a more effective intervention must address the structural problems of bureaucratic capacity and the substantial gaps in the social security system. A universal income grant for all South Africans, as recommended by the Taylor Committee, would address many of the problems identified in this study.

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