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Poverty, HIV/AIDS and Social Security

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EXECUTIVE SUMMARY

This paper builds on an investigation into social security and HIV/AIDS carried out by the by the Economic Policy Research Institute (EPRI) and the Social Disadvantage Research Centre in the Department of Social Policy and Social Work at the University of Oxford, in conjunction with the School of Public Health at the University of the Western Cape. Employing a small purposive survey of severely poor individuals in the Mount Frere district of the Eastern Cape, the research team evaluated the impact of HIV/AIDS and other chronic illnesses on poverty, assessing the role of social security. This paper carries the research further, analysing the data in order to identify linkages between the social security status of the household, the health of members in the household and key socio-economic variables reflecting income, expenditure, investment and human capital accumulation.

The survey indicated that households receiving social grants directed grant expenditure to food, funeral expenses, medical care and education. Findings also show that households receiving a grant were more likely to accumulate assets and had lower school drop-out rates than households not receiving a grant.

The study revealed the importance of private remittances for many poor individuals. Households reporting HIV/AIDS symptoms had the highest percentage receiving remittances, and were less likely to provide remittances to other households. Households receiving social grants were the least likely to receive private remittances.

The findings in this paper raise important questions concerning linkages among poverty, social security status and the health of the household. Current work-in-progress is extending this analysis and, with the benefit of additional field surveys that focus more specifically on these questions, and with a larger sample size, more robust conclusions will be drawn.

1. INTRODUCTION

The HIV/AIDS pandemic raises vital questions about the appropriate policy response for dealing with severe poverty, particularly with respect to social security reform. The increasing mortality associated with HIV/AIDS produces income and expenditure shocks to poor households through a number of transmission mechanisms—through increased human and financial costs of care, loss of income and funeral expenses. This paper examines the linkages between the HIV/AIDS pandemic and poverty, addressing questions relevant to comprehensive social security reform.

This paper builds on an investigation into social security and HIV/AIDS carried out by the by the Economic Policy Research Institute (EPRI) and the Social Disadvantage Research Centre in the Department of Social Policy and Social Work at the University of Oxford, in conjunction with the School of Public Health at the University of the Western Cape. Employing a small purposive survey of severely poor individuals in the Mount Frere district of the Eastern Cape, the research team evaluated the impact of HIV/AIDS and other chronic illnesses on poverty, assessing the role of social security. This paper carries the research further, analysing the data in order to identify linkages between the social security status of the household, the health of members in the household and key socio-economic variables reflecting income, expenditure, investment and human capital accumulation.

2. LITERATURE REVIEW

To begin, one must establish what is meant by “social security.” With all of the problems that developing countries face, many authors have moved away from a narrow definition. “They have broadened the security concept from the income situation to basic

needs in general and they have also widened the range of contingencies. They feel that this is necessary so as to link up traditional social security policies with social and economic policies in general. Getubig for instance defines social security for the developing countries as "any kind of collective measures or activities designed to ensure that members of society meet their basic needs (such as adequate nutrition, shelter, health care and clean water supply), as well as being protected from contingencies (such as illness, disability, death, unemployment and old age) to enable them to maintain a standard of living consistent with social norms"".[1] As discussed above, in this paper social security will be kept in a broad perspective.

HIV/AIDS is an extremely serious health problem that concerns the world today. For Africa, it is the single most important and frightening problem that the country is facing.[2] "At least two-thirds of the world's HIV/AIDS population – 22.5 million – live in this subregion. Countries like Botswana, Namibia, Swaziland, and Zimbabwe have been among the hardest hit nations. Between 20 and 26 per cent of people aged 15 to 49 in these countries are living with HIV/AIDS." [3] The issue now is what to do about this very serious disease. "The epidemic has moved beyond its earlier status as a health issue to become a development issue, with social, political and economic dimensions." [4] Can countries develop social security programmes to deal with HIV/AIDS in a developing country context? If so, how can it be done?

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1 http://www.ilo.org/public/english/protection/socsec/pol/publ/wouter2.htm#ch3 Wouter van Ginneken ,Social Security Department, International Labour Office, Geneva

2 International Labour Office, Geneva. "Action Against HIV/AIDS in Africa." Pg.1. http://www.ilo.org/public/english/protection/trav/aids/pdf/act_agae.pdf.

3 International Labour Office, Geneva. "Action Against HIV/AIDS in Africa." Pg.2. http://www.ilo.org/public/english/protection/trav/aids/pdf/act_agae.pdf.

4 Arndt, Channing; Lewis, Jeffrey D.. "The Macro Implications of HIV/AIDS in South Africa: A Preliminary Assessment." June 200, Pg. 1. http://www.iaen.org/conferences/durbansym/papers/76Arndt.pdf

Arndt and Lewis point out that there are several very important aspects of HIV/AIDS, which include: AIDS tends to strike young adults, AIDS is very slow moving, and infection rates differ by skill class.[5] These aspects will "combine and interact with South Africa's economic structure to affect wages, income distribution, savings rates and other economic variables."[6] They give the example that "despite the higher infection rate forecast for unskilled workers, high unemployment among this group (and the resulting pool of surplus workers) means that the epidemic may drive skilled labour wages higher relative to unskilled wages. If combined with possibly greater AIDS-related medical care burdens (due to higher infection rates and fewer assets), this may result in a substantial worsening of income distribution. Saving rates are also likely to be affected. Most obviously, HIV positive individuals are unlikely to have high savings rates, and may draw down or liquidate existing assets (if they have any) in order to finance medical treatments or offset lost income."[7] Dealing with HIV/AIDS is very costly.

Programmes not only need to be set in place for those who cannot effectively deal with the virus, but these programmes also need to be implemented for anyone who has contracted HIV/AIDS. Although a family unit may be financially stable when the virus is contracted, that can very quickly change if the "bread winner" falls ill and is unable to work.

According to Ainsworth and Teokul (2000) in response to AIDS, "governments should address four areas – overall co-ordination, prevention, care and mitigation—and should 1) monitor national programmes and provide public goods, 2) ensure behaviour

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[5] Arndt, Channing; Lewis, Jeffrey D.. "The Macro Implications of HIV/AIDS in South Africa: A Preliminary Assessment." June 200, Pg. 2. http://www.iaen.org/conferences/durbansym/papers/76Arndt.pdf

[6] Arndt, Channing; Lewis, Jeffrey D.. "The Macro Implications of HIV/AIDS in South Africa: A Preliminary Assessment." June 200, Pg. 2. http://www.iaen.org/conferences/durbansym/papers/76Arndt.pdf

[7] Arndt, Channing; Lewis, Jeffrey D.. "The Macro Implications of HIV/AIDS in South Africa: A Preliminary Assessment." June 200, Pg. 2. http://www.iaen.org/conferences/durbansym/papers/76Arndt.pdf

change among those with the riskiest behaviours, 3) ensure universal access to treatment for opportunistic infections and 4) integrate AIDS into poverty alleviation strategies." [8] Part of the problem becomes the government's hesitation to take action. "AIDS prevention treads on sensitive topics that neither governments nor the public are eager to discuss: sexual behaviour, marital fidelity, prostitution, sexual orientation, and injecting drug use."[9] In the long run, this just worsens the situation. Instead of dealing with the epidemic and trying to combat the harm that has already be done; the problem is just intensified through denial.

In an attempt to assist those families affected by the AIDS epidemic, Jill Donahue suggests a two-pronged approach to provide economic support. The prongs consist of building the economic resources of households and supporting the creation of community safety nets.[10] In the form of a social security programme, this could "assist households in both reducing their risks to economic exposure and improving their ability to cope once a loss has occurred."[11]

Via the first prong, Donahue suggests helping those who are impoverished prior to them being struck with the worst effects of AIDS. By doing so, "they are often able to slow their economic descent and buy themselves enough time to devise adequate coping strategies."[12] In the long run, this may save on some of the burdens that social security programmes may face if the programmes were to wait until there is little that could be done to actually assist those who have the HIV/AIDS virus.

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[8] Baylies, Carolyn. "Overview: HIV/AIDS in Africa: Global & Local Inequalities & Responsibilities." *Review of African Political Economy*. 2000. Pg. 489.

[9] Ainsworth, M.; Teokul, W., "Breaking the Silence: Setting Realistic Priorities for AIDS Control in Developing Countries." Lancet, 356:55-60. http://www.worldbank.org/aids-econ/papers/ainssilence.pdf.

[10] Donahue, Jill. Community –Based Economic Support for Households Affected by HIV/AIDS. United States Agency For International Development. Discussion Paper Number 6. June 1998. Pg. 8.

[11] Donahue, Jill. Community –Based Economic Support for Households Affected by HIV/AIDS. United States Agency For International Development. Discussion Paper Number 6. June 1998. Pg. 8.

[12] Donahue, Jill. Community –Based Economic Support for Households Affected by HIV/AIDS. United States Agency For International Development. Discussion Paper Number 6. June 1998. Pg. 11.

In looking at the second prong, "in many communities heavily impacted by HIV/AIDS, the safety net that keeps many families and households from destitution is comprised of material relief, labour, emotional support, and other assistance provided by community-based organisations."[13] If the government contributed to these community-based organisations, perhaps the programmes could be strengthened into a sort of social security programme that is not totally dependent upon the government, but also involves the community as a whole. Donahue discusses tapping into internal and external resources for community-based organisations and acknowledges that "the needs in many communities affected by HIV/AIDS are too great to be met through modest, traditional fund-raising activities."[14]

There is much information available on HIV/AIDS, but most often there is the inability for it to be accessible and communicated to those people who live in rural areas. An added problem is that those whom live in rural areas are often illiterate or semi-literate, so even if the information were available, it would have to be communicated in a way that could be understood.[15] "People with only limited schooling lack the scientific background necessary for them to understand the causes of the disease and the structure and function of the immune system."[16] They also often lack the knowledge of how to live a healthy life, never mind one that is consumed by the HIV/AIDS virus. The social security programmes that should be set in place, need to start off by dealing with the bare basics such as a healthy diet. These programmes need to then move on to

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[13] Donahue, Jill. Community –Based Economic Support for Households Affected by HIV/AIDS. United States Agency For International Development. Discussion Paper Number 6. June 1998. Pg. 17.
[14] Donahue, Jill. Community –Based Economic Support for Households Affected by HIV/AIDS. United States Agency For International Development. Discussion Paper Number 6. June 1998. Pg. 18.
[15] Page, Sam. "Promoting the Survival of Rural Mothers with HIV/AIDS: A Development Strategy for Southern Africa." *Development*. 2001. 44(4). Pg. 43.
[16] Page, Sam. "Promoting the Survival of Rural Mothers with HIV/AIDS: A Development Strategy for Southern Africa." *Development*. 2001. 44(4). Pg. 43-44.

issues such as: access to counselling and HIV testing, access to nutrient supplements, support groups, etc.[17]

A major obstacle in dealing with the HIV/AIDS crisis is cost. HIV/AIDS has caused health care, medical insurance, death benefits, and disability and pension benefits to skyrocket. "In Zimbabwe, life insurance premiums quadrupled in just two years because of AIDS related deaths."[18] "In the United Republic of Tanzania and in Zambia, large companies reported that AIDS illness and health costs surpassed their total annual profits. In Botswana, companies estimated that AIDS-related costs would increase from under 1 per cent of salary costs to 5 per cent in only six years due to the rapid rise in infections in the last several years. At the national level, the effect could be even more serious."[19] It is evident that something needs to be done, but one often wonders where to start. Again, education about HIV/AIDS and prevention of the virus seems the place to start. Stopping AIDS from spreading is key along with slowing its development.

An objective for many countries is social security, but it is very difficult to obtain and far from being widely accomplished. "Only two countries in the region—Zimbabwe and Zambia actually have a national social security system and Namibia's is still underdeveloped."[20] Botswana is developing a social security system. "In addition, Zambia has a national provident fund and in South Africa, the state provides a "safety

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[17] Page, Sam. "Promoting the Survival of Rural Mothers with HIV/AIDS: A Development Strategy for Southern Africa." *Development*. 2001. 44(4). Pg. 44.

[18] International Labour Office, Geneva. "Action Against HIV/AIDS in Africa." Pg.9. http://www.ilo.org/public/english/protection/trav/aids/pdf/act_agae.pdf.

[19] International Labour Office, Geneva. "Action Against HIV/AIDS in Africa." Pg.9. http://www.ilo.org/public/english/protection/trav/aids/pdf/act_agae.pdf.

[20] Loewenson, Rene; Whiteside, Alan. "Social and Economic Issues of HIV/AIDS in Southern Africa." A Consultancy Report Prepared for SAfAIDS, Harare. March 1997. Pg. 28-29. www.iaen.org/impact/sfaids1.pdf.

net" pension to people who do not qualify for private pension schemes."[21] From Zimbabwe southwards, there is greater development of private coverage by death and invalidity insurance and retirement funds. In general, social security benefits and employee benefits need an extensive amount of work. "Some formal sector employment such as government service or jobs in large, possibly foreign, companies may include sickness benefits and pensions, but the great majority of the workforce in Africa is not covered by any form of medical let alone unemployment insurance."[22] Due to the high demands that HIV/AIDS has placed upon the system, social protection for workers has been placed on hold. "The other side of the social security picture is investment: life insurance and pension funds are important sources of capital for the government as well as the private sector. A reduction in contributions, and an increase in payments—both inevitable consequences of HIV/AIDS—will result in a reduced supply of capital investment."[23] In regard to social security, the International Labour Office has begun to attempt to assess the demographic impact of AIDS.

> *"This model is an important tool for actuarial work on social insurance schemes in countries with high AIDS prevalence, notably in southern and eastern Africa. This basic tool will be further improved and completed in order to simulate the medium- to long-term impact of AIDS on the labour supply, employment, productivity, growth and poverty levels. It will make possible a projection of various social expenditures such as health, education and social services, as well as cash benefits in formal sector social insurance schemes. It will then establish the links between social expenditure and government budget by estimating changes in government social expenditure and revenues over time. In addition, the combination of an AIDS mortality model and social budget*

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[21] Loewenson, Rene; Whiteside, Alan. "Social and Economic Issues of HIV/AIDS in Southern Africa." A Consultancy Report Prepared for SAfAIDS, Harare. March 1997. Pg. 29. www.iaen.org/impact/sfaids1.pdf.
[22] International Labour Office, Geneva. "HIV/AIDS in Africa: The Impact of the World of Work." Pg. 20. December 2000. http://www.ilo.org/public/english/protection/trav/aids/pdf/adftext.pdf .
[23] International Labour Office, Geneva. "HIV/AIDS in Africa: The Impact of the World of Work." Pg. 20. December 2000. http://www.ilo.org/public/english/protection/trav/aids/pdf/adftext.pdf .

model will permit cost benefit analysis of different degrees and intensities of early awareness campaigns."[24]

Again, the key to this working is early education and awareness of HIV/AIDS. Hopefully with an understanding of the problem, people can learn from past mistakes. It appears that prevention is a necessity in order to combat this epidemic. "Based on the assumption that early awareness would reduce infection rates and the morbidity and mortality associated with HIV/AIDS, the negative impact of the disease on government revenues, expenditures and economic growth would be reduced."[25]

International Social Security Associate President Johan Verstraeten in his opening address on September 9th, 2001 at the General Assembly stated that, "Everyone has the right to be covered by a social security scheme regardless of nationality, race, gender or religion." He also indicated that, "social development is an essential basis for economic development and political stability."[26] HIV/AIDS has caused great devastation all over the world. The virus has hit extremely hard "in Sub Sahara Africa, which accounts for over 70 per cent of people infected globally." [27]

3. DATA ANALYSIS

While the sample size of the study did not support in depth statistical investigation, analysis of the database did identify a number of important issues. In particular, the analysis investigated the income, expenditure and investment patterns of the households, examining the impact of social security and household health status.

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[24] International Labour Office, Geneva. "Action Against HIV/AIDS in Africa." Pg.19. http://www.ilo.org/public/english/protection/trav/aids/pdf/act_agae.pdf.

[25] International Labour Office, Geneva. "HIV/AIDS: A Threat to Decent Work, Productivity and Development." Pg. 35. June 2000. http://www.ilo.org/public/english/protection/trav/aids/pdf/aidse.pdf.

[26] ISSA FOCUS, News and Information on ISSA Activities. No.2-2001. www.issa.int/pdf/publ/Focus/2focus2.pdf

[27] Towards Earth Summit 2002, Social Briefing No. 1. "Aids- The Undeclared War."

Households were divided into those that had succeeded in qualifying for and actually receiving a social grant, and those that had not. In addition, three categories of health status were identified:

(1) those households with at least one member reporting possible symptoms of HIV/AIDS,

(2) households with no members reporting possible symptoms of HIV/AIDS but indicating another long term chronic illness or ailment, and

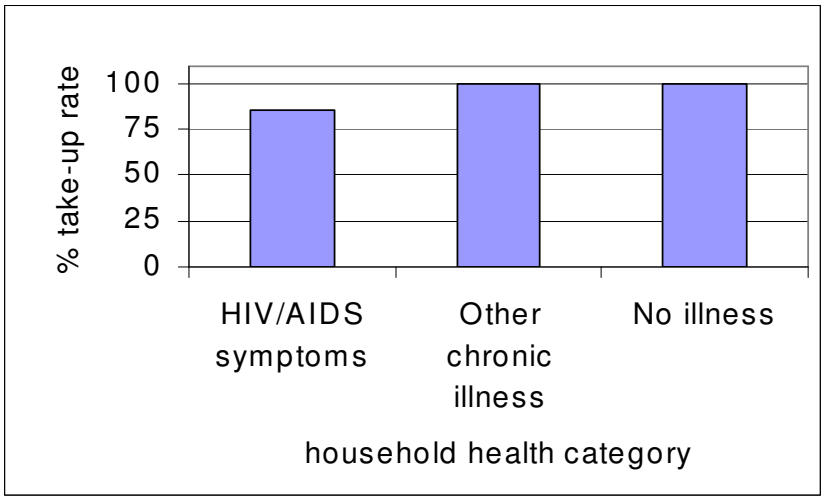
(3) households reporting no major health problem.

The main source of income for households in this sample is the State Old Age Pension, providing fifteen pensioners with an income more than twice the average reported by the employed workers in the sample.

3.1 STATE OLD AGE PENSION TAKE-UP RATES

Figure 1 documents the take-up rates for the pension. None of the take-up rates are significantly different from 100 per cent, reflecting the success of the Department of Social Development in distributing this key anti-poverty resource.

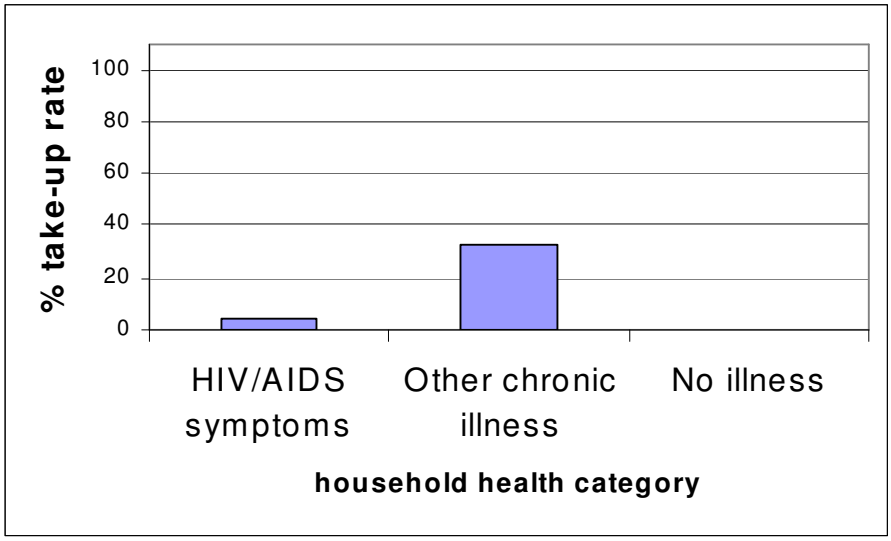
Figure 1: State Old Age Pension take-up rates by household health category



3.2 CHILD SUPPORT GRANT TAKE-UP RATES

The take-up rate for the Child Support Grant, however, reflected a much more dismal situation. Only three care-givers (caring for a total of four children) had succeeded in qualifying for and actually receiving the Child Support Grant. Figure 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



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 hypothetical explanation warranting testing examines the behaviour of social development caseworkers exercising undue discretion in the approval of grants. If

caseworkers ignore the objective means test and apply a subjective test, they might be more likely to approve a care-giver in a household suffering from severe chronic illness, such as HIV/AIDS or another ailment. Households with all healthy members might not elicit the sympathetic discretion of a caseworker abusing the process in this fashion.

Another possible explanation is that households with less healthy members might already qualify for another social grant, such as the Disability Grant or the State Old Age 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,

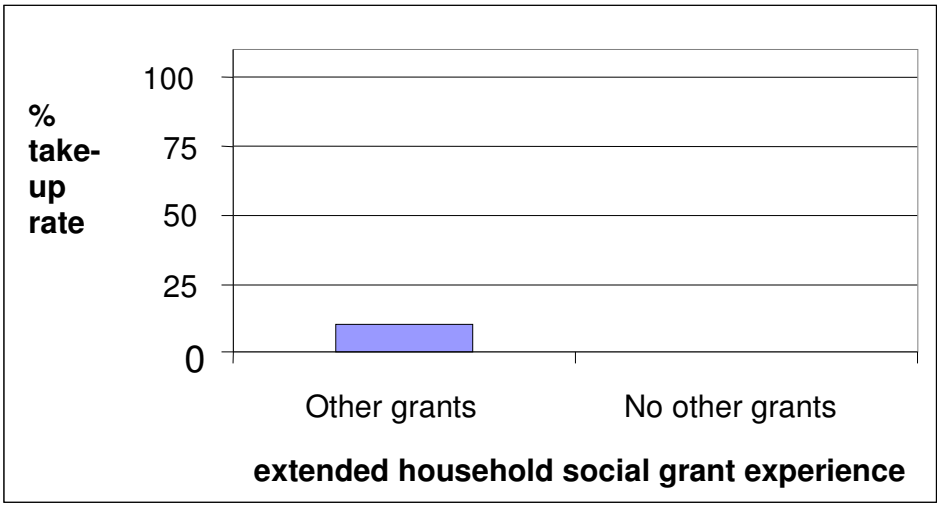
(3) the caregiver might be known to the caseworkers in the Social Development office.

Figure 3 depicts the take-up rates for the Child Support Grant for two groups:

(1) those children in households with some extended household experience with the Disability Grant or the State Old Aged Pension, and

(2) those households with no members having ever successfully qualified for a social grant.

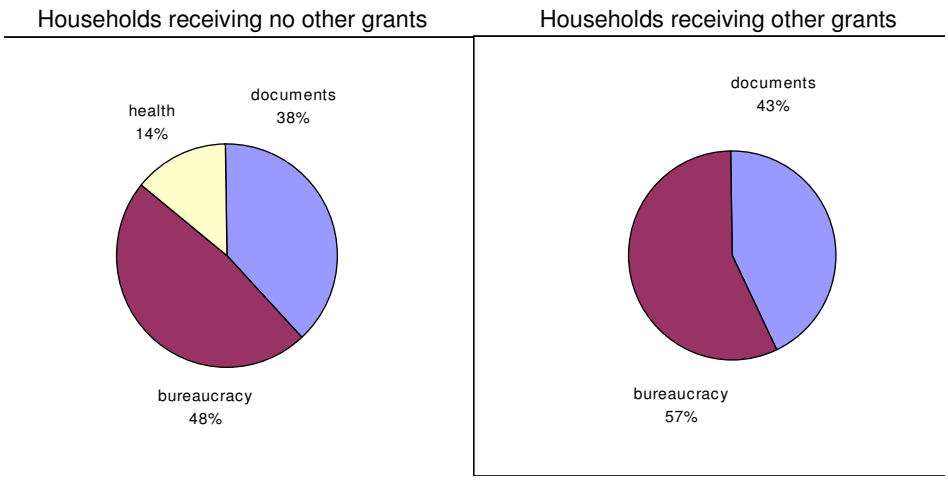
Figure 3: CSG take-up rates depend on experience with other social grants



The take-up rate for children in households with a successful application for another social grant was ten percent. 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, possessing 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 care-givers, due to poverty shocks or HIV/AIDS-related deaths, complicate the documentation required for successful application for the Child Support Grant.

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

Figure 4: Major reasons cited by households for failure to receive Child Support Grants

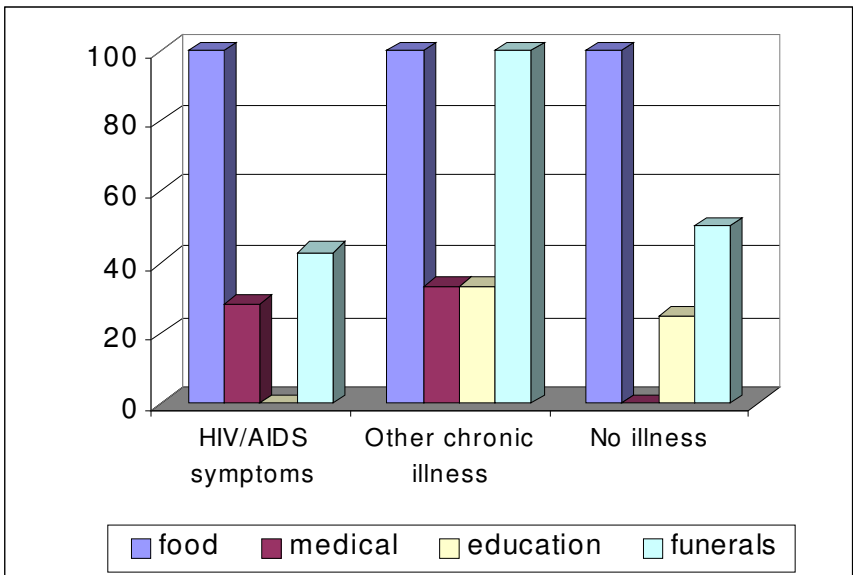


For both groups, failure to possess the necessary documents is the single most cited explanation. In particular, lack of birth certificates, bar-coded identification documents and Road-To-Health cards with care-giver names consistent with the child's birth certificate were major problems. The larger 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. In addition, three care-givers cited health reasons.

3.3 EXPENDITURE PATTERNS

Households who succeeded in receiving a social grant demonstrated significant consistency in reporting how the resources were spent. All households reporting 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.

Figure 5: How households increase spending when receiving a social grant (by category)

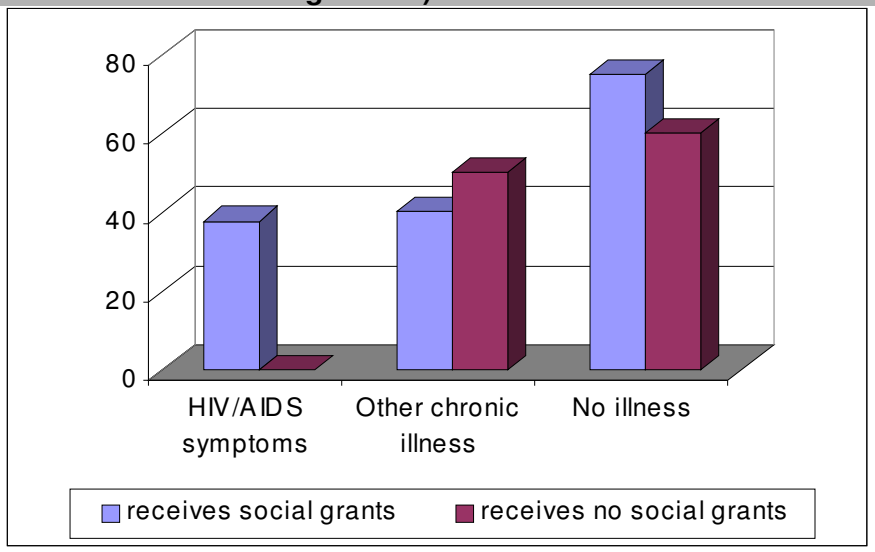


3.4 CAPITAL ACCUMULATION

Households receiving a grant were also more likely to accumulate assets. 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 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.)

Figure 6: Percentage of households selling assets (livestock) in past year – as percentage of households owning assets)

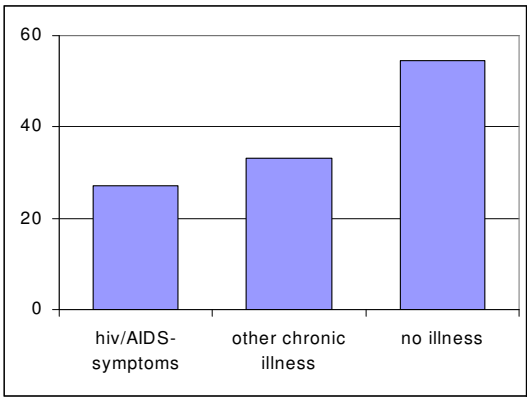


Households with members reporting other chronic illnesses has a moderately high incidence of selling livestock over the previous year, with these households receiving social grants relying moderately less on asset sales. Households with no reported illnesses had the highest incidence of asset sales, with households receiving grants having the highest proportion of selling livestock.

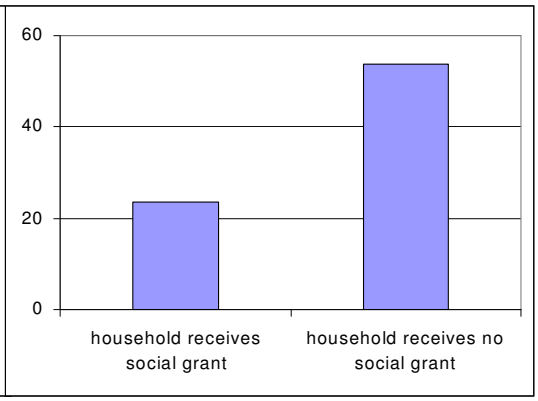
Household health and social security status also affected the accumulation of human capital. HIV/AIDS affects schooling in a number of important ways. First, to the extent that it causes income failure, the resulting poverty reduces resources available for education. Second, by debilitating the care-giver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

Figure 7: Percentage of households with school-aged children leaving school

By household health category



By social grant category



The most significant determinant of school drop-out 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.

3.5 RECEIPT OF PRIVATE REMITTANCES

In the absence of an effective and comprehensive public social safety net, individuals rely on private remittances for their survival. This study underscored the importance of private remittances for the very poor members of the sample. The study found important impacts of HIV/AIDS and social security on the private safety net in the Mount Frere region.

Figure 8: How does HIV/AIDS and social security effect the receipt of private remittances?

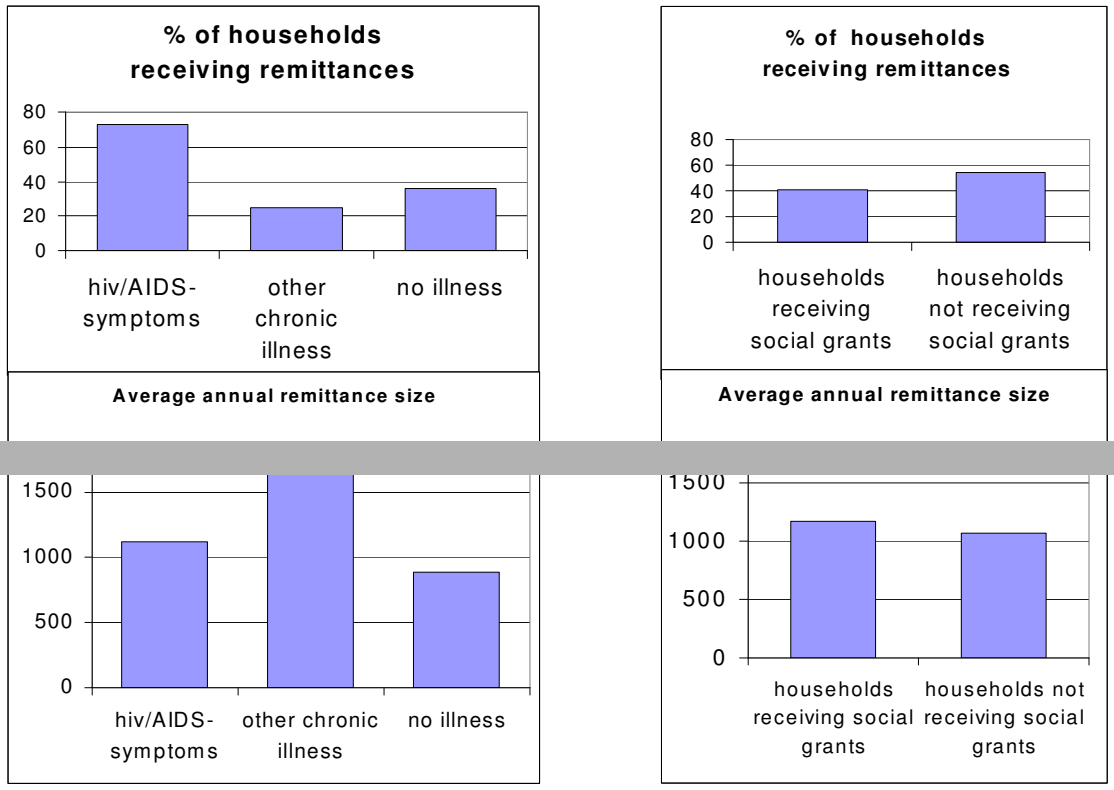
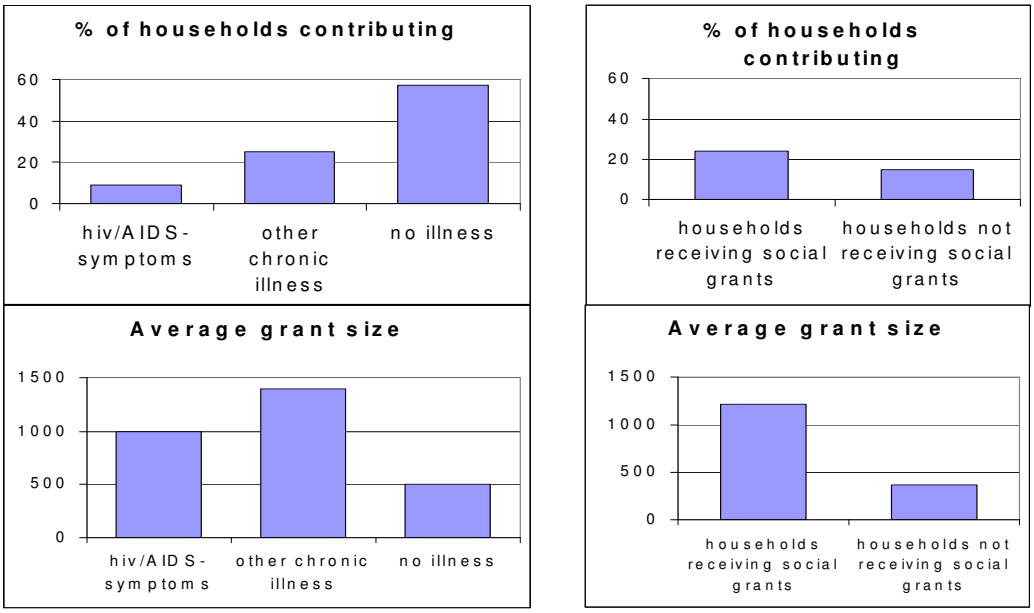


Figure 9: How does HIV/AIDS and social security affect the contribution of private remittances?



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 grants received by households across the health categories. 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 in the study clearly explained the different magnitudes.

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 percent 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. 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 explainer of both the incidence of contributors and the average size of the remittance. 24 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.

4. CONCLUSION

The survey of severely poor individuals in the Mount Frere district of the Eastern Cape indicated that households receiving social grants directed grant expenditure to food, funeral expenses, medical care and education. Findings also show that households receiving a grant were more likely to accumulate assets and had lower school drop-out rates than households not receiving a grant.

The study revealed the importance of private remittances for many poor individuals. Households reporting HIV/AIDS symptoms had the highest percentage receiving remittances, and were less likely to provide remittances to other households. Households receiving social grants were the least likely to receive private remittances.

The findings in this paper raise important questions concerning linkages among poverty, social security status and the health of the household. Current work-in-progress is extending this analysis and, with the benefit of additional field surveys that focus more specifically on these questions, and with a larger sample size, more robust conclusions will be drawn.

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