

Social grants as safety net for HIV/AIDS-affected households in South Africa¹

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ABSTRACT

South Africa has a well-developed system of social security and the reach of the social grant safety net has expanded rapidly over the past five years. Social grants are likely to play an important role in mitigating the impact of HIV/AIDS, given that eligibility for these grants is driven largely by the increasing burden of chronic illness, the mounting orphan crisis and the impoverishment of households associated with the epidemic. This paper investigates the role of social grants in mitigating the socio-economic impact of HIV/AIDS in South Africa, using data from a panel designed to investigate the household impact of the epidemic. Data were collected from a total of 351 purposively sampled households interviewed four times over a period of two and a half years. Affected households were more dependent on income from social grants compared with households that had never experienced morbidity or mortality. A significantly larger proportion of affected households qualified for social assistance. Access to the old age pension remained relatively stable, highlighting the high take-up rate of this grant, while access to the child support and disability grant increased over time. Yet, take-up of these grants remains low and there is still much scope to improve take-up rates. Social grants also play an important role in poverty alleviation. The rate of poverty reduction continued to increase over time in affected households, but remained relatively stable in the case of households that had not experienced morbidity or mortality. This saw the gap in the incidence, depth and severity of poverty between affected households and households that had not experienced morbidity decline. Social grants also translated into a significant reduction in the severity of poverty in affected households.

Keywords: HIV/AIDS, poverty, social assistance, public transfers, social grants, South Africa.

RÉSUMÉ

Le système de sécurité sociale de l'Afrique du Sud est très bien développé et le filet de sécurité de subventions sociales s'est répandu assez rapidement au cours de cinq dernières années. Les subventions sociales joueraient un rôle important en atténuant l'effet du VIH/SIDA, étant donné que le droit à ces subventions est largement influencé par l'augmentation du fardeau des maladies chroniques, la crise des orphelins qui s'accroît, ainsi que l'appauvrissement des foyers associé à l'épidémie. Cette article étudie le rôle de subventions sociales qui atténuent l'impact socio-économique du VIH/SIDA en utilisant des données provenant d'une commission d'enquête. Cette commission a pour mission d'examiner l'effet de l'épidémie sur un foyer. Des données ont été requis auprès de 351 foyers interviewés en tant qu'échantillon ciblé. Ces foyers ont été interviewés à quatre reprises au cours de deux ans et demi. Les foyers qui sont touchés par l'épidémie dépendaient beaucoup plus sur les subventions par rapport à ceux qui n'ont jamais été affectés par la morbidité et la mortalité. Une grande partie de foyers affectés a droit à l'aide sociale. L'accès à la retraite est resté relativement stable tandis que l'accès au soutien d'enfant et à la pension d'invalidité a augmenté au cours du temps. Pourtant, les demandes de subventions restent assez basses et il y a encore beaucoup de travail à faire afin d'améliorer le taux de demandes. Les allocations sociales jouent un rôle important en réduisant la pauvreté. Le rythme de réduction de la pauvreté a continué à augmenter au cours du temps dans des foyers touchés. Toutefois, dans le cas des foyers non-touchés, le rythme de réduction est resté relativement stable. De ce fait, l'écart créé par la fréquence, la profondeur et la gravité de la pauvreté entre les foyers affectés et ceux qui ne le sont pas diminue. Les allocations sociales ont réduit la gravité de pauvreté de manière significative dans les foyers affectés.

Mots clés: le VIH/SIDA, la pauvreté, l'aide sociale, le transfert public, les allocations sociales, l'Afrique du Sud.

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NOTE: 'social assistance' and 'public transfers' is the common terminology used to describe these types of programmes, while 'social grants' is a more local term. I am of the opinion that the inclusion of the former two terms, in addition to 'social grants' will allow more searches to locate this article.

Introduction

South Africa faces one of the highest HIV rates in the world. The estimated adult prevalence of HIV among the 15 - 49 age group in 2001 was 20.1% (UNAIDS, 2002). The ASSA2000 model puts adult prevalence among the 20-65 age group at 24.1% (ASSA, 2003). A recent national household survey in South Africa has put the 2002 estimate of adult prevalence among those older than 25 years at 15.5% (Sishana & Simbayi, 2002).

The socio-economic impact of HIV/AIDS serves to create a vicious cycle of poverty and disease. As adult members of the household become ill and are forced to give up their jobs, household income will fall. To cope with the change in income and the need to spend more on health care, children are often taken from school to assist in caring for the sick or to work so as to contribute to household income. Because expenditure on food comes under pressure, malnutrition often ensues, while access to other basic needs such as health care, housing and sanitation may also come under threat. This further reduces the resistance of infected adults and children to opportunistic infections, given lower levels of immunity and knowledge, which in turn leads to increased mortality (Gaffeo, 2003; World Bank, 1998). Therefore, HIV/AIDS and the associated burden of morbidity and mortality expose already vulnerable households to further shocks (Desmond, 2001; Poku, 2001; Whiteside, 2002), locking poor households into a spiral of underdevelopment.

Yamano and Jane (2002), Booysen (2003) and Cogneau and Grimm (2003) report empirical evidence on this link between poverty and HIV/AIDS. Shisana and Simbayi (2002) in turn reported HIV prevalence to be higher among households of lower socio-economic status. HIV prevalence among persons aged 15 years and older who lived in households that did not have enough money or were often short of money to afford basics was 14%, compared with between 5 and 6% in households with enough money to afford most

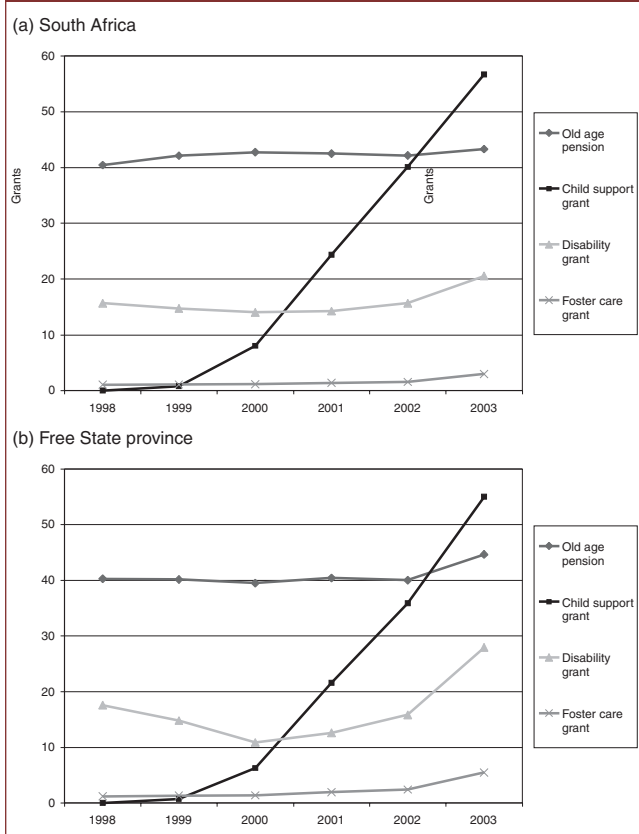
important things or extras. What role then have social grants to play in alleviating the burden of poverty on HIV/AIDS-affected households?

South Africa has a well-developed system of social security that is on a par with systems in many developed countries, unlike in many other developing countries (Guthrie, 2002; Seekings, 2002). This system includes a non-contributory pension system, as well as a number of social grants aimed at assisting households in caring for children and for the disabled. The discussion in this paper distinguishes between five specific social grants (i.e. old age pensions [R700/month], the child support grant [R160/month], the disability grant [R700/month], the care dependency grant [R700/month], and the foster care grant [R500/month]), as well as access to grants in general (defined as access to any one of these five grants). Between 1998 and 2003 the total number of grant beneficiaries in South Africa increased from 2.8 to 5.8 million (Fig. 1). In the case of the Free State province, this number increased from 181 to 366 thousand. In terms of grants per 1 000 population, national coverage increased from 67 to 125, compared with 66 to 134 grants per 1 000 population in the Free State province. Average annual growth in the number of beneficiaries was 15% both for South Africa and the Free State province. The reach of the social grant safety net expanded relatively rapidly over this period regarding the number of grant beneficiaries. However, this has not been the case with all social grantsⁱⁱ

In total, the number of persons receiving old age pensions increased from 1.7 to 2 million over the period 1998 - 2003. This represents average annual growth in coverage of 3%. The next highest increase in coverage has been in the number of persons benefiting from disability grants. The total number of beneficiaries has increased from 660 to 953 thousand over this period, translating into an average annual growth rate of almost 8%. The number of beneficiaries from foster care grants increased at an average annual rate of 26% over the 5 years, rising from 43 to 138 thousand between 1998 and 2003. In relative terms, however, coverage is low compared with the old age pension and child support grant. Most marked was the increase in the coverage of the child support grant over this relatively short period, as was highlighted by Guthrie (2002). The number of beneficiaries on average grew at 138% per annum, rising from 34

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Fig. 1. Numbers of grant beneficiaries (1998-2003). (Note: The number of grant beneficiaries per 1 000 population was calculated by dividing the annual number of reported beneficiaries in April of each year by the respective mid-year population estimate published by Statistics South Africa (2003b). These mid-year population estimates include extra deaths due to HIV/AIDS.)



thousand in 1998 to a staggering 2.6 million by April 2003. Trends in the number of grant beneficiaries in the Free State province for the most part mirror national trends.ⁱⁱⁱ

Apart from the role of social grants in general in alleviating poverty, the old age pension, child support, disability, care dependency, and foster care grants in particular are also likely to play an important part in mitigating the socio-economic impact of the HIV/AIDS epidemic, given the associated increase in morbidity and mortality, the orphan crisis and the resulting impacts on household composition and formation (Guthrie, 2002; Seekings, 2002; Van der Berg & Bredenkamp, 2002). The old age pension and the disability, care dependency and foster care grants furthermore are all relatively large grants (the current monthly Rand values of each of these grants as reported by the National Treasury (2003) are noted above in parentheses), and are therefore likely to play a

particularly important role in supporting poor, affected households.

This paper employs descriptive analysis to investigate the role of social grants in mitigating the socio-economic impact of HIV/AIDS, with the aid of data from a panel designed to investigate the household impact of the epidemic. Section 1 presents an overview of the data and method.^{iv} Section 2 reports on the contribution of social grants to total household income. Section 3 describes trends in access to social grants. Section 4 explores the role of social grants in alleviating poverty, and Section 5 presents conclusions.

Data and method

The household impact of HIV/AIDS was assessed by means of a cohort study of households affected by the disease. The survey was conducted in two local communities in the Free State province, one urban (Welkom) and one rural (QwaQwa), in which HIV/AIDS is particularly rife. Households were defined in terms of the standard definition employed by Statistics South Africa in the October Household Survey (OHS), i.e. 'a person or a group of persons who live together at least four nights a week' (Statistics South Africa, 1995: p. 0317-E). A survey of the quality of life and household economics was conducted. Interviews were conducted with one key respondent only, namely the 'person responsible for the daily organisation of the household, including household finances'. The results reported in this paper are based on an analysis of data for those households interviewed in each of the first four waves of the study. The four waves of data collection were respectively completed in May/June and November/December of 2001 and in July/August and November/December of 2002. (Eventually, a total of six waves will be conducted over a 3-year period.)

Comparisons are drawn here between so-called affected households, affected households that have experienced a high burden of morbidity or mortality (which represents a subset of affected households), and households that have not experienced morbidity or mortality in any period. Affected households were sampled purposively via NGOs and other organisations involved in AIDS counselling and care, and at baseline included at least one person known to be HIV-positive or known to have died from AIDS in the past 6 months. Informed consent was obtained from the infected individual(s) or their caregivers (in

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the case of minors). The incidence of morbidity and mortality is notably high in affected households. The morbidity and mortality experienced by affected households exhibit a classic HIV/AIDS pattern, with large numbers of adults (i.e. those aged 15 – 49 years) having experienced illness or having died. Between 70 and 80% of morbidity and mortality in affected households can be attributed to HIV/AIDS or related infectious diseases and opportunistic infections (Bachmann & Booysen, 2003; Booysen, Bachmann, Matebesi, & Meyer, 2003). In order to explore the socio-economic impact on affected households of repeated occurrences of HIV/AIDS-related morbidity or mortality, what Freire (2003, p. 373) calls 'the chronic impacts of the epidemic', a distinction was made between affected households in general and affected households that had experienced morbidity or mortality in three or four waves of the panel. These so-called affected households were compared with households selected from among those households identified as a home physically near to each affected household and that had not experienced a recent death or chronic illness at any time. At baseline, neighbouring households that included a person currently being treated for tuberculosis, or having been admitted to hospital for pneumonia in the past month, were not considered for inclusion in the study. (These households were not called 'non-affected households', as is the common practice, given that they may have included HIV-positive persons.) Yet, the classification of households employed in this analysis, albeit useful for the purposes of our analysis, belies the fact that HIV/AIDS affects entire communities, and affects various households directly or indirectly at different stages of the epidemic, rather than affecting only households that directly experience morbidity and mortality (Freire, 2003).

Standards of living were measured here at the household rather than the individual level, given that the focus was on the household impact of HIV/AIDS. Poverty was interpreted in terms of the command over commodities that resources afford people via income and consumption (Lipton & Ravallion, 1995). The concern, therefore, was with 'poverty proper' (i.e. resource adequacy) and not with the physiological, sociological or political dimensions of poverty (Kgarimetsa, 1992; Woolard & Leibbrandt, 1999). (One should note that the complex nature of the association between poverty and HIV/AIDS also requires that

capability, social exclusion and participatory approaches to poverty eradication be focused on in this research topic, as argued by Stewart (2003) — approaches that could not be explored here due to the nature of the survey.)

Data were collected from one informant regarding employment income, non-employment income (which includes social grants) and receipt of remittances for the members of the particular household. An estimate of total monthly household income was derived from these figures by adding up the various component items. Where appropriate, income estimates for the four waves were converted into real values using the most recent CPI estimates (2000 = 100) published by Statistics South Africa (2003a). Households with the same level of income do not necessarily enjoy the same level of welfare. The larger the household, the lower the level of welfare at similar levels of household income. Measures of equivalent income were employed to allow for these differences in standard of living related to household characteristics (Burkhauser, Frick & Schwarze, 1997; Lipton & Ravallion, 1995). Household income was adjusted for differences in household size by dividing total monthly income by n^{-1} , where n represents the number of household members and an adjustment for household economies of scale (Filmer & Pritchett, 1998, p. 13). According to Lanjouw and Ravallion (1995), a coefficient of 0.6 represents an adequately robust and reliable adjustment for household economies of scale. Poverty was measured at the household level using a poverty line of R250 real adult equivalent income per month. These data on household income and access to social grants were employed in investigating the role of social grants in mitigating the socio-economic impact of HIV/AIDS.

Due to the sampling design and small sample size, the findings from this household impact study cannot be generalised to households across South Africa, but pertain largely to the experience of poor, African households that utilise public health care services (Booyesen *et al.*, 2003). The subsequent analysis, albeit based on data from a relatively small, purposive sample, presents a telling picture of the socio-economic impact of the HIV/AIDS epidemic, a characteristic shared by most other HIV/AIDS household impact studies (Booyesen & Arntz, 2003).

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Contribution of social grants to total household income

If social grants are to play an important role in mitigating the socio-economic impact of the epidemic, one would expect affected households to be more dependent on income from social grants compared with households that have not experienced morbidity or mortality.

Table 1 reports the composition of real adult equivalent per capita income. Affected households in general and affected households that had experienced a greater burden of morbidity and mortality in particular were more dependent on social grants compared with households that had never experienced morbidity or mortality ($p < 0.005$). A smaller proportion of the income of affected households that have experienced morbidity or mortality in three or four periods consisted of employment income compared with households that had never experienced morbidity or mortality ($p < 0.005$). The main explanation for this is the relatively high levels of unemployment and low labour force participation rates in affected households (Booyesen *et*

al., 2003), as well as the greater eligibility of affected households for social grants (discussed in section 4). Differences in the contribution to household income of other non-employment income and remittances were not statistically significant. Given the relatively high proportion of the income of affected households made up by social grants, it is likely that social grants play an important role in alleviating poverty in HIV/AIDS-affected households. Before the discussion turns to the impact of social grants on poverty, however, trends in access to social grants are discussed in more detail.

Access to social grants

Given the pro-poor bias in the sampling design, relatively large proportions of households received an income from any one or more of five types of social grants, namely the old age pension and child support, disability, foster care and care dependency grants. Regarding the general trends in access to social grants over the four waves, the evidence in Table 2 suggests that coverage in general had increased, both for affected households and for households that had not experienced morbidity or mortality, which mirrored

Table 1. COMPOSITION OF REAL ADULT EQUIVALENT PER CAPITA INCOME

| Source of income | Affected households | | Affected households that experienced morbidity or mortality in three or four periods | | Households that had not experienced morbidity or mortality | |
|-----------------------------|---------------------|------------|--|------------|--|------------|
| | Rand (2000=100) | Percentage | Rand (2000=100) | Percentage | Rand (2000=100) | Percentage |
| Employment income | 283 | 48 | 195 | 43 | 592 | 64 |
| Grant income | 116 | 36 | 127 | 39 | 71 | 18 |
| Other non-employment income | 28 | 6 | 16 | 6 | 43 | 5 |
| Remittance income | 28 | 10 | 37 | 12 | 43 | 13 |
| Total | 455 | 100 | 375 | 100 | 750 | 100 |
| Sample (N) | 143 | | 72 | | 103 | |

Table 2. PERCENTAGE OF HOUSEHOLDS THAT RECEIVED ANY SOCIAL GRANT

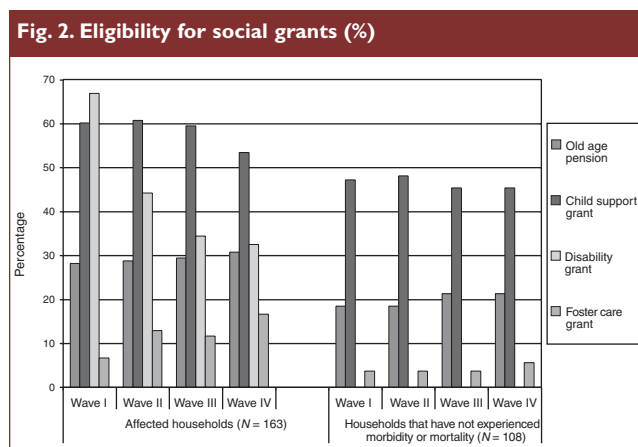
| Wave | Affected households | Affected households that experienced morbidity or mortality in three or four periods | Households that had not experienced morbidity or mortality |
|------------|---------------------|--|--|
| I | 47 | 48 | 28 |
| II | 49 | 52 | 29 |
| III | 51 | 52 | 35 |
| IV | 53 | 58 | 42 |
| Sample (N) | 163 | 72 | 108 |

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the trends in provincial numbers of beneficiaries. The proportion of households that received a social grant was significantly higher in the case of affected households and affected households that had experienced a high burden of morbidity or mortality when compared with households that had not experienced morbidity or mortality ($p < 0.05$). However, the picture looks quite different when one considers access to social grants, i.e. the percentage of those households that were eligible to receive a grant that actually received such grant, rather than simply coverage, i.e. the number of households that benefited from a particular grant.

Eligibility was defined in relatively crude terms, given that the survey instrument was not designed to assess the eligibility of households to qualify for social assistance, but rather to collect information on the socio-economic circumstances of these households. Eligibility was defined as follows for each of the different social grants:

- Old age pension (OAP): Household included a male aged 65 years or older and/or a female aged 60 years or older.
- Child support grant (CSG): Household included at least one child aged 7 years or younger.
- Disability grant (DG): Household included persons ill for 20 or more days in the month preceding the interview and/or ill persons who were not able to perform daily tasks (e.g. work/play, recreation, household tasks, personal hygiene, mobility) by themselves.
- Foster care grant (FCG): Household included at least one child aged 15 years or younger whose mother and father reportedly was not alive (a double orphan).
- Means test: Households that did not currently receive any of these four grants, but qualified for such grant in terms of the above criteria were only considered eligible if average real adult equivalent per capita income was less than R250 per month. Although this is not the means test as applied by the Department of Social Development in assessing grant eligibility, the use of this poverty line as means test does provide some basis for excluding non-poor households. Households that received a particular grant were automatically assumed to be eligible to receive such grant. This may of course not necessarily be true, given the fallibility of the grant application process.^v

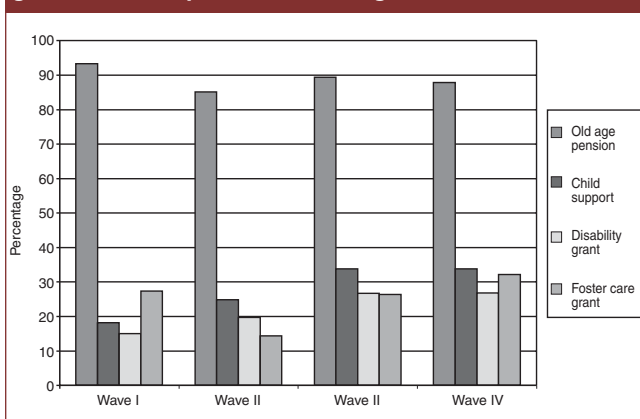


Access was then calculated as those households that actually received a grant expressed as a percentage of those households that were eligible to receive a grant (based on the above criteria) or that actually received a grant.

Fig. 2 reports the percentage of households that were eligible to receive social grants. A high proportion of affected households were eligible to receive old age pensions ($p < 0.10$) and child support grants ($p < 0.05$ for 3/4 waves), given that HIV/AIDS has seen households headed by or including elderly persons increasingly taking care of orphaned children, grandchildren or sick adult children as the epidemic takes its toll. The relative stability in the percentage of households that qualified for an old age pension most likely reflects the relative low mobility of the elderly.^{vi} The fluctuations over time in the percentage of households eligible to receive a child support and foster care grant reflect the relatively high mobility of young children and of orphaned children (Booyesen *et al.*, 2003). Given the high burden of morbidity in affected households (Booyesen *et al.*, 2003), a considerable proportion of affected households qualified for a disability grant ($p < 0.001$). However, the percentage of affected households eligible to receive such a grant declined over time as the burden of morbidity on affected households declined (Bachmann & Booyesen, 2003). These fluctuations in eligibility for disability grants may partly reflect the mobility of ill persons, a number of whom had left their respective households over the study period, while it also reflects the fact that some grantees had died in subsequent periods of the study.^{vii} The number of households eligible to receive a foster care grant increased over time as rates of orphanhood increased and as the orphan crisis took its toll

(Booyesen *et al.*, 2003). As expected, more affected households qualified for a foster care grant compared with households that had not experienced morbidity or mortality ($p < 0.05$ for 3/4 waves). For the most part, therefore, a significantly larger proportion of affected households qualified for social assistance compared with households that had not experienced morbidity or mortality.

Fig. 3. Percentage of affected households eligible for a social grant that actually received a social grant



Given that a large proportion of affected households qualify for social assistance, the focus now falls on access to grants. In other words, did affected households actually benefit from the social assistance for which they qualified? Fig. 3 reports the percentage of affected households eligible for social grants that accessed grants. The take-up of the old age pension was very high, with almost 90% or more of affected households having accessed an old age pension. Access to the old age pension remained relatively stable over the period, highlighting the high take-up rate of this grant (Case & Deaton, 1998; Samson, Babson, Haarmann, Haarmann, Khati, Macquene, *et al.*, 2002). Access to the child support grant increased markedly over time, which mirrored the trends in the numbers of provincial grant beneficiaries. The decline in the number of affected households eligible to receive a disability grant translated into a marked increase in access. However, the absolute number of grantees remained relatively constant over time (14–16), thus belying the reported wholesale increase in the number of grant beneficiaries at the provincial level. There was no clear-cut trend in the percentage of affected households that accessed foster care grants. The absolute number of grantees, however, increased from 3 to 9 over the study period, thus supporting the evidence of a general increase in the number of grant

beneficiaries at the provincial level. The fluctuations in take-up rates for the foster care grant most likely reflect the relatively high mobility of orphaned children (Booyesen *et al.*, 2003; Young & Ansell, 2003). The question remains however as to whether the general increase in access to social grants documented in these pages has translated into poverty alleviation in households affected by the epidemic.

The role of social grants in poverty alleviation

There is a body of evidence that has highlighted the role of social assistance in South Africa in poverty alleviation (Lund, 1999; Samson, 2002; Samson *et al.*, 2002; Seekings, 2002; Woolard, 2003). Much of the earlier work on the impact of social grants (or social assistance or targeted transfers) on poverty focused on the success of the old age pension (Case & Deaton, 1998; Jensen, 2004) and the importance of this source of income for household security and household food security (Lund, 1999). Ravallion (2003) emphasises the important role of targeted transfers in alleviating poverty, based on growing evidence of some successes that contradict the often held belief that the benefits of targeted transfers are captured by others or that coverage of such transfers is too low to make any real difference. Devereux (2002, p. 657) in turn argues that social safety nets can help mitigate chronic poverty insofar as part of welfare transfers is invested in 'income-generating activities, education, social network, and the acquisition of productive assets'. Yet, research on social grants also shows that a large proportion of the South African population (as much as half of the population according to one report) would remain in poverty even if take-up rates of current grants were 100% (Samson, 2002; Samson *et al.*, 2002; Seekings, 2002; Woolard, 2003).

Affected households, and in particular affected households that had experienced a high burden of morbidity or mortality, were relatively worse off than households that had not experienced morbidity or mortality. This was the case regardless of whether income, expenditure or food expenditure were employed as measures of household welfare. The incidence, depth and severity of poverty were worse among affected households compared with households that had not experienced morbidity or mortality, especially in the case of affected households that had experienced morbidity or mortality in each wave. This was the case regardless of the choice of poverty line or

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poverty measure. Affected households were also more likely than households that had not experienced morbidity or mortality to have slipped into poverty, while a relatively larger proportion of affected households, and in particular affected households that faced a greater burden of illness or death, were classified as chronically poor (Booyesen *et al.*, 2003). Social grants, therefore, are likely to play a particularly important role in keeping affected households from slipping deeper into poverty, and in some cases ensuring that households do not slip into poverty.

In order to explore the relative importance of specific events associated with changes in household welfare, we followed an approach similar to that employed by Leibbrandt and Woolard (2001).^{viii} For the sake of simplicity, the focus here was only on those cases where access to a social grant was discontinued in any subsequent period and where the household did not receive a grant for the remainder of the period. Likewise, the emphasis was only on those cases where a household that did not receive a social grant at baseline gained access to a grant in any subsequent period and where the household received such grant in each of the remaining periods. (There are obviously more permutations, but the link between these transitions in access to grants and changes in income can only be analysed with more advanced statistical techniques.) Households were considered to have 'gotten ahead' ('fallen behind') if average adult equivalent household income calculated across waves II to IV had increased (decreased) by at least 10%

since baseline, an approach that according to Leibbrandt and Woolard (2001, p.683) reduces errors resulting from errors in the measurement of income. No distinction was made between affected households and households that had not experienced morbidity or mortality, given that the numbers of households that gained access to social grants ($N = 38$) or that lost access to social grants ($N = 18$) were too small to allow a meaningful analysis at the disaggregate level. The results of these analyses are presented in Table 3.

As expected, households that had gained access to social grants, especially the relatively larger grants, were more likely to have gotten ahead. In general, more than half of households that gained access to social grants got ahead. Almost three-quarters of those households that gained access to an old age pension got ahead, while almost three-quarters of households that gained access to the disability grant got ahead. Just more than 40% of households that gained access to the foster care and child support grants got ahead. Not surprisingly, the child support grant, the smallest of these grants, did not consistently aid households in escaping poverty. Almost 40% of households that gained access to a child support grant over the study period still ended up falling behind. However, even in the case of the foster care grant, 28% of households that gained access to the child support grant over the study period actually fell behind, compared with 17% of those that gained access to the disability grant and none of those that gained access to an old age pension. This highlights the complexity of poverty

Table 3. ABSOLUTE CHANGE IN ADULT EQUIVALENT INCOME BETWEEN WAVES I AND IV FOR HOUSEHOLDS THAT GAINED AND LOST ACCESS TO SOCIAL GRANTS (%)

| | Old age pension (R700/month) | Child support grant (R160/month) | Disability grant (R700/month) | Foster care grant (R500/month) | Any social grant |
|--|---------------------------------|-------------------------------------|----------------------------------|-----------------------------------|------------------|
| A. Household gained access to social grants | | | | | |
| Got ahead | 72 | 41 | 65 | 43 | 55 |
| No change | 27 | 19 | 17 | 28 | 5 |
| Fell behind | 0 | 39 | 17 | 28 | 40 |
| Total | 100 | 100 | 100 | 100 | 100 |
| Sample (N) | 11 | 41 | 23 | 7 | 38 |
| B. Household lost access to social grants | | | | | |
| Got ahead | 19 | 18 | 10 | 50 | 17 |
| No change | 31 | 55 | 60 | 0 | 22 |
| Fell behind | 50 | 27 | 30 | 50 | 61 |
| Total | 100 | 100 | 100 | 100 | 100 |
| Sample (N) | 16 | 11 | 10 | 2 | 18 |

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transitions and the need to investigate the determinants of changes in poverty status, including changes in household composition, which are closely linked to access to social grants.

Regarding social grants in general, more than half of households that lost access to a social grant fell behind (Table 3), thus highlighting the relative importance of grant income in explaining changes in household welfare. The results were not clear-cut in terms of the association between changes in poverty status and a discontinuation in access to specific social grants. Only in the case of the foster care grant and old age pension did a relatively large proportion of households that lost access to such grant fall behind. Yet, a discontinuation in access to grants at least ensured that households maintained their absolute standard of living, with less than 20% of households that lost access to an old age pension or a child support or disability grant getting ahead. Yet, more than half of the households that in subsequent periods lost access to a foster care grant had actually gotten ahead. Although these results need to be interpreted with caution due to the small sample size ($n < 5$), this may hint at the success of targeting social grants at the poor, i.e. households that got ahead not qualifying for a grant anymore (the same argument applies to the

findings that show that a relatively large proportion of households that gained access to a grant had fallen behind in certain cases).

Another, perhaps more common way of exploring the poverty impacts of social grants is to calculate the standard poverty measures for income inclusive and exclusive of grants (Bhorat, 2003; Samson *et al.*, 2002; Woolard, 2003). This allows one to assess the impact of social grants on the incidence, depth and severity of poverty.^{ix} Poverty was measured at the household level using a poverty line of R250 real adult equivalent income. These results are reported in Table 4, with a distinction being made between affected households, affected households that had experienced a high burden of morbidity and mortality, and households that had not experienced morbidity or mortality. These poverty measures were simply calculated based on total household income exclusive of grants. No adjustments were made for a so-called 'tax credit', given that households in the absence of social grants will pay less taxes insofar as government will not have to raise taxes to pay for public expenditure on social grants. Therefore, the results in Table 4 present only a crude estimate of the impact of social grants on the incidence, depth and severity of poverty. In addition, it would be worthwhile to perform this analysis by type

Table 4. POVERTY MEASURES INCLUSIVE AND EXCLUSIVE OF GOVERNMENT GRANTS (%)

| | Affected households (N =143) | | | Households that had not experienced morbidity or mortality (N =103) | | |
|--------------------------------|------------------------------------|------------------------------------|----------------------------------|---|------------------------------------|-------------------------------------|
| | Income excluding government grants | Income excluding government grants | Reduction in poverty measure (%) | Income excluding government grants | Income excluding government grants | Reduction in government measure (%) |
| Incidence of poverty (P_0) | | | | | | |
| Wave I | 59.4 | 42.7 | 28 | 38.8 | 26.2 | 33 |
| Wave II | 54.5 | 34.3 | 37 | 38.8 | 25.2 | 35 |
| Wave III | 57.3 | 37.1 | 35 | 39.8 | 23.3 | 42 |
| Wave IV | 62.9 | 37.1 | 41 | 43.7 | 27.2 | 38 |
| Depth of poverty (P_1) | | | | | | |
| Wave I | 41.2 | 17.0 | 59 | 23.7 | 11.0 | 54 |
| Wave II | 41.7 | 14.3 | 66 | 23.1 | 11.3 | 51 |
| Wave III | 40.7 | 14.4 | 65 | 26.1 | 10.6 | 59 |
| Wave IV | 42.3 | 11.0 | 74 | 28.0 | 10.6 | 62 |
| Severity of poverty (P_2) | | | | | | |
| Wave I | 34.2 | 9.9 | 71 | 18.3 | 6.2 | 66 |
| Wave II | 36.2 | 9.1 | 75 | 17.7 | 6.6 | 63 |
| Wave III | 35.7 | 8.3 | 77 | 20.8 | 7.1 | 66 |
| Wave IV | 35.3 | 5.0 | 86 | 22.8 | 6.0 | 74 |

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of grant to assess the impact of different types of grants on poverty. For example, one would expect the disability and foster care grants to contribute significantly towards poverty alleviation in affected households. For the sake of simplicity and due to constraints of space, however, this paper focuses on the impact of social grants in general on poverty.

Social grants played an important role in alleviating poverty, not only in affected households, but also in households that had not experienced morbidity or mortality (Table 4). In percentage terms, the incidence, depth and severity of poverty dropped considerably over the period. The reduction in the incidence, depth and severity of poverty since baseline (i.e. the percentage change in the poverty measure calculated at baseline exclusive of social grants, and the poverty measure calculated at wave IV inclusive of social grants) was more pronounced in affected households compared with households that had not experienced morbidity or mortality. The incidence of poverty declined by 38 and 30% since baseline in affected households and households that had not experienced morbidity or mortality respectively. The depth of poverty declined by 73% since baseline in affected households, compared with 55% for households that had not experienced morbidity or mortality. The severity of poverty declined by 85 and 67% since baseline in affected households and households that had not experienced morbidity or mortality respectively. Importantly, though, the rate of poverty reduction continued to increase over time in affected households, but remained relatively stable in the case of households that had not experienced morbidity or mortality. This saw the gap in the incidence, depth and severity of poverty between affected households and households that had not experienced morbidity decline. The depth and severity of poverty in affected households by wave IV were more or less on a par with households that had not experienced morbidity or mortality. The incidence of poverty was still somewhat higher in affected households compared with households that had not experienced morbidity or mortality. Most importantly, the reductions in the severity of poverty since baseline were statistically significant in the case of affected households ($p < 0.05$). Hence, social grants have resulted in a significant reduction in the severity of poverty in affected households. This suggests that social grants play an important role in alleviating poverty (bringing people closer to the poverty line),

more so than eradicating poverty (lifting people out of poverty).^x

Conclusion

Affected households in general, and those affected households that had experienced a greater burden of morbidity and mortality in particular, were more dependent on social grants compared with households that had not experienced morbidity or mortality. Given the pro-poor bias in the sampling design, relatively large proportions of households had access to social grants. The evidence on access to social grants presented here emphasises the likely importance of the child support, disability and foster care grants in mitigating the impact of HIV/AIDS, given that increased eligibility for these grants is largely driven by the increasing burden of chronic illness, the mounting orphan crisis and the impoverishment of households associated with the epidemic. Yet, the evidence shows that take-up rates for child support, disability and foster care grants remain relatively low and there is still much scope to improve take-up rates for social grants.

Social grants play an important role in alleviating poverty. As expected, households that had gained access to social grants, especially the relatively larger grants, were more likely to have gotten ahead. Not surprisingly, the child support grant, the smallest of these grants, did not consistently aid households in escaping poverty. Reductions in the incidence, depth and severity of poverty since baseline were considerable, both in affected households and in affected households that had not experienced morbidity or mortality. Importantly, though, the rate of poverty reduction continued to increase over time in affected households. This saw the gap in the incidence, depth and severity of poverty between affected households and households that had not experienced morbidity or mortality decline over time. Most importantly, the reductions in the severity of poverty since baseline were statistically significant in the case of affected households. Therefore, social grants play an important role in alleviating poverty (bringing very poor people closer to the poverty line) in affected households, more so than eradicating poverty (lifting people out of poverty). However, the sheer magnitude of the epidemic in South Africa also requires one to consider the fiscal affordability and sustainability of such a system in the longer run.

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Footnotes

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[‡]The discussion in this paper is limited to the four social grants with the widest coverage (i.e. largest numbers of beneficiaries), namely the old age pension and the child support, disability and foster care grants. The care dependency grant, although important in the context of the HIV/AIDS epidemic, was excluded from discussion in this paper due to the relatively small number of beneficiaries in the Free State province (2 474 by April 2003) as well as the relatively small number of households in the sample population that had access to a care dependency grant ($N < 10$).

[§]The number of disability and foster care grants awarded per 1 000 population is slightly higher than was the case for South Africa as a whole. This may reflect the fact that the Free State province, which has relatively high HIV prevalence compared to most other provinces (i.e. 27.6% adult prevalence according to ASSA (2003) model versus 14.9% adult prevalence according to Shisana and Simbayi (2002)), other things being equal, may have seen the number of beneficiaries increase at a more rapid rate than elsewhere, given the greater impact of the epidemic in this particular province.

[¶]The main advantage of panel data is that it allows the researcher to distinguish between households that over time have experienced certain events infrequently, i.e. at certain points in time only, as opposed to households that have not experienced any change in their circumstances, i.e. either never or at all points in time. For example, a panel survey allows one to consider the extent to which households move into and out of poverty over time, or alternatively remain in poverty (May, Carter, Haddad & Maluccio, 2000; May & Roberts, 2001). Analysis that employs data from cross-sectional surveys conducted at different points in time to distinguish trends in key outcomes (often the only option in the absence of panel data) cannot explore this dynamic nature of household economics.

^{¶¶}One cannot assess eligibility perfectly given firstly the lack of detailed information on grant recipients and other household members to apply grant criteria as formulated; and secondly that the available information does not reflect the situation in the particular household when they actually applied for the grant but rather current circumstances when the household was already a grant recipient.

^{¶¶¶}Family history studies in general assume the elderly to be immobile, despite little empirical, historical work having specifically investigated the phenomenon of migration of the elderly (Neven, 2003).

^{¶¶¶¶}These claims cannot be substantiated with the aid of these data, because the source of grant income is only recorded at the household and not at the individual level. Keller (2002) notes that this is a problem common to other household surveys employed by researchers in analysing the relationship between changes in household composition and access to social grants.

^{¶¶¶¶¶}Woolard and Leibbrandt (2001) also determined the nature of the main income events associated with changes in poverty status. An analysis of this nature applied to the data exhibited no statistically significant differences between affected households and households that had experienced no morbidity or mortality in terms of changes in specific types of income. This most probably was the result of the relatively small number of households that have not experienced morbidity or mortality that moved into ($N = 25$) and out of poverty ($N = 26$), with less than 14 households experiencing any one type of main income event between any two consecutive waves of the panel. It is hoped that data from the complete panel will enable the author to perform such analysis with a larger number of observations.

^{¶¶¶¶¶¶}The headcount, poverty gap and squared poverty gap indices are special cases of the Foster-Greer-Thorbecke (FGT) class of poverty measures. $P_{\alpha} = 1/n \sum [z - y_i/z]^{\alpha}$, where z represents the poverty line and y_i the actual income or consumption level of each person or household. The three FGT measures each focus on a different conventional poverty measure. P_0 , P_1 and P_2 respectively are derivatives of the headcount (H), poverty gap (PG) and squared poverty gap (SPG) indices (Greer & Thorbecke, 1986). These poverty measures become more sensitive to the well-being of the poorest person as the value of α increases (Woolard & Leibbrandt, 1999, p. 28). The trends over time in the incidence, depth and severity of poverty in affected households that experienced a high burden of morbidity and mortality, not reported here due to constraints of space, were similar to the trends for affected households in general, although these reductions were achieved off a higher base.

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