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"Taking Care of My Own Blood": Older Women's Relationships to their Households in Agincourt

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"TAKING CARE OF MY OWN BLOOD": OLDER WOMEN'S RELATIONSHIPS TO THEIR HOUSEHOLDS IN AGINCOURT

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ABSTRACT

The implications of aging populations, which in the more developed world center around issues of social security health service provision and eldercare, are further complicated in areas of the developing world with high prevalence of HIV/AIDS. Elders are being asked to take on additional financial, emotional and physical responsibilities due to the HIV/AIDS-related illnesses and death of their children. The Agincourt Health and Population Unit fieldsite, from which this study's ethnographic and survey data come, is situated in the rural north-east of South Africa, in a province with an estimated 33% prevalence of HIV/AIDS. Women in the African context are bearing much of the burden of care related to HIV/AIDS. In this context, I examine the intersection of age and gender, exploring the roles that older women, in particular, are playing in their households, and how those roles are affected by the presence of illness and death of prime-aged adults. Using a mix of quantitative and qualitative data, I show the high percentage of children and adults living in a household with an older woman, and, further, the importance of the caretaking roles older women are taking on in the households in which they live.

INTRODUCTION

Elders in developing countries with high HIV/AIDS prevalence face the same concerns such as health care, social security, and old-age care as elders everywhere. In addition, they face the unique consequences of AIDS that affect both the support they receive from and the contributions they make to their families and households. Although a small percentage of elderly are infected or at risk for infection at this stage of the epidemic in South Africa, the majority of elderly are much more likely to be *affected* by HIV/AIDS than *infected* with the disease. As prime-aged adults become ill and die from HIV/AIDS, elders are being left without support and caregiving from their children; and, they are taking on responsibilities for sick adult children and orphans.

In addition to age, gender is playing an important role in shaping the HIV/AIDS burden of care in the African context. Women are more likely than men to take on caregiving activities relating to both the sick and the left-behind. For elderly women, this may mean contributing to their household through financial, emotional and physical means. These contributions may be a continuation of duties that an older woman has always seen as her responsibility, or they may represent new commitments that she had shed when her own children were grown and now must take on again.

AIMS

This paper explores the relationships that currently exist between elderly women and their households in the Agincourt Health and Population Unit (AHPU) study site, an area in the rural northeast of South Africa with approximately 18% HIV/AIDS prevalence. Although in places I will look specifically at households that have experienced an HIV/AIDS death, the purpose of this paper is to paint both a quantitative and qualitative picture of older women's

caregiving responsibilities in their households through cross-sectional individual and household level quantitative data from the 2003 Agincourt Health and Demographic Surveillance System (AHDSS) census, and semi-structured interviews from the Gogo (Grandmother) Project whose 30 respondents were sampled from the 2003 AHDSS database. Although some of the women in the Gogo Project sample are getting support from the family members with whom they live, the majority are playing important caregiving roles for the sick, as well as for foster and orphan children living in their households.

BACKGROUND

HelpAge International (HAI), a non-governmental organization that conducts both academic and advocacy work focusing on aging populations, stresses that the HIV/AIDS epidemic has had and will continue to have a huge impact on the elderly (HAI 2003, 2002, 2000). However, very little research has explored the impact HIV/AIDS has on the roles the elderly take on and the relationships they have with family members who are infected with and affected by HIV/AIDS. Older people are likely to be primary caregivers for HIV positive kin and partners, and for AIDS orphans (Barnett & Whiteside 2002; Deininger, Garcia & Subbarao 2001; Knodel, Watkins, & VanLandingham 2002).

As caregivers, elders often experience emotional and financial stress (Yamano & Jayne 2004; Steinberg *et al.* 2002), deteriorations in their health (Ainsworth & Dayton 2003), as well as increased loneliness and isolation due to changing family structure, and stigma from the community (Ogden & Nyblade 2005; Nyblade *et al.* 2005; Sontag 1998). Many of these elders expected financial, emotional or physical support from their adult children; as these children die from HIV/AIDS, the elderly lose *their* caregivers, while often simultaneously becoming caregivers for their orphaned grandchildren (Kakwani & Subbarao 2005).

Prime-age adult deaths have economic consequences on households where the elderly live. Yamano & Jayne (2004) find that in Kenya poor households are slow to recover economically from head-of-household adult mortality. Economic consequences can be produced both from reduced income, as Yamano & Jayne (2004) show, and from increased expenditures. The elderly are often left with the debts incurred from HIV/AIDS-related illnesses. The costs of HIV/AIDS-related morbidity are further compounded when a death occurs, resulting in substantial funeral-related expenditures (Steinberg *et al.* 2002).

Elderly South Africans may receive a small means-tested non-contributory government pension. Women become eligible at age 60, men at age 65. Due to poverty and extremely high rates of unemployment, the elderly household member's pension may be the most stable and reliable income for many households (May 2003). This makes turning to the elderly for economic support a particularly viable strategy in South Africa. In the era of HIV/AIDS, pension income may help to diminish the impact of HIV/AIDS-related economic shocks, such as the cost of illness, funerals, and caring for orphans (Kikwani & Subbarao 2005; Schatz & Ogunmefun 2005).

Both elderly men and women are likely to be impacted by the death of adult children to AIDS. Caregiving responsibilities for both the sick and orphaned, however, usually split along gender lines, with mothers, wives and sisters bearing the larger burden (Ferreira 2004, Knodel, Watkins & VanLandingham 2000). Due to the focus on women as caregivers, elderly women are particularly likely to feel the effects of the HIV/AIDS epidemic. In Zimbabwe, a WHO and HAI study found that of caregivers over age 50 who were caring for AIDS orphans, 73% were 60 years or older, and 74% of all the caregivers were women (WHO 2002).

This research begins to look at the ways in which older women are contributing to their households—households that have suffered from the loss of an adult member, as well as those that have not. Their contributions may be particularly vital in households with many fostered or orphaned children, households that have few working prime-aged adults, and households that have suffered economic shocks from the illness and death of household members or outside kin. This paper focuses most on the physical contributions that older women make to their households.

DATA & METHODS

Both the quantitative and qualitative data come from the AHPU study site, which is situated in South Africa's rural northeast. The AHPU site is in Limpopo Province, which has a prevalence rate estimated at 18% (South African Department of Health 2003). The AHDSS conducts a yearly census to track births, deaths, and migration. In addition, it collects verbal autopsy data, identifying a primary cause for each death occurring in the site. As of the annual census in 2003, the site was home to 70,272 people, from 11,665 households in 21 villages. In the analysis below, I use age (60 for women, 65 for men) as a proxy for pension-eligibility since the AHDSS has not collected data on pension-receipt. All descriptive quantitative analyses will use AHDSS census data collected in 2003.

For the qualitative project, I selected 30 South African women aged 60-75 (and therefore eligible for pensions) from the AHDSS 2003 census with whom to conduct in-depth interviews. Using verbal autopsy data, I was able to select households stratified by their mortality experience. I selected 10 women from each of three groups of households defined by 2001 to 2003 mortality experience: (1) an HIV/AIDS adult death had occurred, (2) a non-HIV/AIDS-related adult death had occurred, and (3) no adult death had occurred. We wanted to capture

recent deaths to facilitate recall about caregiving, but we did not enter homes where a death had occurred in the last year out of respect for the local mourning process.

Of the 30 women on the original sample list, 24 were interviewed; after selecting alternates to replace those who could not be interviewed, the team was able to interview 30 women. Reasons for non-response included: two women had had a recent death in their households; one refused; one had moved away; and, two had died since the 2003 census. (See Schatz & Ogunmefun 2005 for a more detailed description of sampling and response rates.) The interviews were conducted by three local women over the age of 40, whom I trained in qualitative interviewing. Each interviewer was responsible for 10 respondents with whom they conducted all interviews; in addition, each interviewer translated and transcribed her own interviews. While in the field, as project PI, I read each interview, reviewed queries with the interviewers, and wrote individual interview guides for later interviews to fill gaps, follow-up on interesting issues and explore new questions.

For the purpose of this paper, I will look at how the older women in all of the households in the sample spoke about their relationships to other members of their families and households, and the roles that they play within their households. Although there is a means test for the pension, all but one of our respondents were receiving pensions (Schatz & Ogunmenfun 2005). In select cases, I will highlight some of the unique roles that older women play in the ten households that experienced an HIV/AIDS death. Individual quotations from the qualitative work in the text below will be followed by a pseudonym for the respondent and the strata into which the household fell.

RESULTS: QUANTITATIVE PICTURE

In 2003, women over age 60 were just 4% of the total population of the Agincourt site; however, almost a quarter of households (22.2%) include an older woman [see Table 1].[1] Men over the age of 65, were only 1.6% of the AHPU population, and live in a smaller proportion of households (9.5%). Only 5.4% of all households have more than one member age-eligible for pension —the majority of these are husband-wife pairs (about 90% of multiple pension-eligible households), the remainder are mainly households with more than one female pensioners, most likely sisters. Since here I look at a cross-section of the AHDSS data, I am unable to determine the reasons why an elderly person is in a given household or how their presence may or may not relate to HIV/AIDS. Future work will explore if households with elderly members are more likely to have HIV/AIDS-related deaths, or if the elderly or other household members' movement occur shortly before or after a death.

TABLE 1 ABOUT HERE

Despite the small numbers of pension age-eligible adults in the site (5.5%), nearly 30% of non-age-eligible individuals in the site live in households with pension age-eligible individuals; and, over a quarter of children under the age of 15 live in a household with an age-eligible pensioner. The majority of these individuals live with a *woman* over the age of 60. For children, this is especially true; 84% of children under 15 who live with an age-eligible pensioner, live with a female age-eligible pensioner (a male age-eligible pensioner may also live in some of these households).

[1] The percent over the age of 60 varies in developing country populations. The proportion elderly in the AHDSS of 5.6 is actually below the projected percentage in South Africa as a whole, of 6.7%. In developing countries, the percent over the age of 60 ranges from as high as nearly 19% in former Soviet Republics of Belarus and Georgia. The lower end of the spectrum are mainly African countries, with the majority having 4 to 5% of their populations over the age of 60. Data from http://www.unfpa.org/profile/compare.cfm. UNDP used medium variant projections for the year 2005 to estimate population size and age structure (UNPD 2001).

TABLE 2 ABOUT HERE

Table 2 shows mean household size for all households and those with and without a woman over the age of 60. The mean household size in the AHDSS is 6.02. Households with no woman over age 60 have significantly fewer members (5.7 on average) compared to those with a woman over 60 (7.0 on average). Although the differences in mean number of children in households without or with an older woman, and with two or more pension age-eligible adults are small, the differences are significant at the .01 level.

TABLE 3 ABOUT HERE

As Table 3 shows, the percent of households with one or more children differs little for households with a woman over age 60 and those without. Households with a woman over the age of 60, however, are much more likely than other households to host foster children and maternal orphans. In the AHDSS, a foster child is defined as a child whose mother is alive, but living elsewhere. Maternal orphans are defined as children whose mother is dead. The AHDSS does not capture paternal residence or orphans. Therefore, we cannot know from the AHDSS data whether a child's father is present/absent or alive/dead, making these likely undercounts of orphanhood if not also fosterage.

Just under one-sixth of all households are home to at least one foster child, whereas over a quarter of the households with an older woman have one or more foster children. This pattern is even more dramatic for maternal orphans; 5.5% of all households compared to nearly three times as many households with an older woman (15.9%) have at least one maternal orphan.

Although one-dimensional, i.e. without controls for wealth, household mortality profiles, or other potentially important correlates, these simple cross-tabulations begin to show a surprising presence of older women in AHPU households. Their presence is particularly notable

in households that have potentially vulnerable members, such as foster children and orphans. The qualitative data will help highlight the roles of older women in their households.

RESULTS: QUALITATIVE PICTURE

The quantitative data create a picture of the presence of children, foster children, and orphans living in households with older women. The AHDSS data cannot, however, describe the role that older women are playing in these children's lives. It is possible that older women are living in households with children to receive support, for instance assistance with household tasks and financial maintenance. As the qualitative data show, for some women, this is the case. For many of the women, however, their "mothering" roles of caring for the young and the sick are extended into their pension years and to their grown children and young grandchildren. It is not possible to say from these data if this is a new phenomenon, but it is possible to describe the overwhelming reality for women over the age of 60, which includes caring for their grown children when they become ill and caring for foster and orphaned grandchildren who reside in their homes.

Children Supporting Parents

There is perhaps a certain level of expectation among women over the age of 60 that the children they raised will support them in their old age. For respondents whose children were gainfully employed, this was often the case. This financial assistance sometimes comes from children living inside the house, or in the form of cash remittances from a child who has migrated outside of the area for employment. At times this support comes not just in the form of cash, or even in-kind assistance with food and other subsistence needs, like home improvements, but also in the form of physical support by taking over chores. Household chores like cooking, cleaning, collecting firewood and water may become difficult for older women, particularly the

latter two that include both walking long distances and carrying large loads. Having a child or grandchild living in the household who conducts these chores makes a significant difference in the lives of some of our respondents.

Emily, a divorced 65 year-old, lives with four unmarried daughters and three grandchildren. One of these grandchildren is an 18 year-old grandson, who was sent by a married daughter who lives in a village about 50 kilometers away to live with and assist her. "I asked his parents if [my grandson] could stay with me so that I can send him to fetch water, [which is difficult for me to do] because I am old. My other grandchildren are still young [so they cannot help yet]" (Emily, No Death Household). Similarly, Maria's son who lives in Johannesburg sent one of his sons to help, "They said that he must stay with me and help me with some difficult jobs, for example going to fetch water, because we walk for kilometers to fetch water. He also protects me and the house" (Maria, Other Death Household). Some respondents also receive financial assistance from employed children living within and outside their homes. However, many more respondents spoke about the financial (see Schatz & Ogunmefun 2005) and physical responsibilities they continue to shoulder despite aging and sometimes their own ailing health.

Caring for the Sick

The theme of caregiving is something about which we asked explicitly in each household we interviewed. We asked if the respondent had been or was currently the primary caregiver for anyone who was sick in the household. Although we did not designate a time period, most of the caregiving, particularly for grown children, had occurred in the last five years. Over two-thirds of our respondents mentioned caring for an ill adult child (presently or in the past), one-third mentioned having taken care of an ill husband, and about half mentioned helping to care for other kin like grandchildren, daughters-in-law, siblings and parents. [See Table 4]. More women

living in households where there had been an HIV/AIDS death than women from the other two strata reported having cared for an ill adult child. More of the women in the other two groups reported taking care of someone other than an adult child. It is likely that the women in HIV/AIDS households also took care of husbands and other kin, but we concentrated on learning about the adult child's illness.

TABLE 4 ABOUT HERE

Older women described their caregiving activities as including a diverse array of activities and financial responsibilities. These included feeding, bathing, fetching and preparing treatments, washing soiled clothing and blankets, and helping the ill person to the pit latrine (none of our respondents had flush toilets or piped water). Thandizile cared for her ill son, assisting his wife, "I used to wake up in the morning and boil water for him to bathe, cook soft porridge for him" (Thandizile, HIV/AIDS Household). Sinah was also taking care of a sick adult child, her daughter, who Sinah admitted probably had AIDS, "[My daughter], when she came here, she was seriously ill. I had to wash her, I had to carry her to the toilet [pit latrine]; she couldn't walk a long distance. I had to carry her to the toilet [pit latrine] behind the house. When she finished, I had to carry her back to the house. Then, I had to go back, take a spade and throw the feces in the toilet" (Sinah, HIV/AIDS Household).

Older women's caregiving responsibilities also included traveling with the sick person to the traditional healer, clinic, private doctor or hospital to receive care and treatment. Sometimes they helped the patient walk to these places, and sometimes they paid for the transportation costs—for an older woman the former most likely has physical costs, whereas the latter has clear financial costs. Constance alludes to both issues, "It was difficult in case of money because of moving [my daughter] up and down to hospitals, hiring cars to send her to hospitals. I even

borrowed from my neighbors to send her to hospitals. …My heart is painful, I suffered a lot about my daughter moving up and down on clinics, hospitals, and doctors. But [still], my daughter passed away after suffering for a long time" (Constance, No Death Household).

A large number of the respondents' adult children were not living in the household when they became ill, particularly those who are or were suffering from HIV/AIDS, but were brought "home" for care. Some of our respondents spoke of caregiving as a mother's responsibility, others denigrated daughters-in-law who did not properly care for their ill sons, forcing the respondent to take over these responsibilities. Auphrey took care of an HIV positive daughter and also is taking care of her son who lives near her. She said, "Any child who becomes sick in our culture, while their parents are still alive, the mother must take care of her child" (Auphrey, HIV/AIDS Household). Grace had a different opinion. Her son, who recently returned from Johannesburg without his wife, was thin, coughing, and tested positive for HIV. She complained about her daughter-in-law's reliance on her to care for him, "A city woman runs away when her husband is sick. She only comes back when her husband is okay" (Grace, No Death Household).

Caring for Grandchildren

On average, the women with whom we spoke lived with four to five grandchildren or great-grandchildren. The maximum number of children under age 15 in a household was thirteen, and the most common was just two. The configurations of households varied greatly. Most households had three generations, but very few were simply a grandmother living with an intact family unit (i.e. parents and their children). Some respondents lived with grandchildren whose parents were not resident in the house (due to mortality, migration, or non-marital births), as well as other of the respondents' grown children.

Regardless of kin configurations, many of our respondents took on physical and financial caregiving responsibilities for their grandchildren (Schatz & Ogunmefun 2005). These grandmothers purchased and washed their clothes, bought food and cooked for them, paid their school fees and took them to school, fetched water and firewood for them, and bathed them when they are young. Essentially, these older women acted as parents to their children's children. Despite extensive qualitative data, it was difficult to decipher which children were foster children or orphans and which had parents living in the households. Even when our respondents were acting as the primary caregiver for their grandchildren because the children's parents were absent, they sometimes claimed there were no orphans or foster children in a household. These contradictions further emphasized how fully these respondents had taken on the duties of parent to their grandchildren.

Anna lives in a household with her grown son and daughter, one daughter who is still in school, and three grandchildren. She is the foster parent to two of these grandchildren; Anna's daughter who gave birth to these children lives elsewhere with a man who is not the children's father. Since her daughter is unemployed, Anna takes full responsibility for these children, "[My daughter] gave birth to the children while she was staying here at home. She was not married. The children grew up in my house. I take them as my children" (Anna, Other Death Household). Although Anna is proud of her role in her grandchildren's life, she sometimes finds caregiving challenging,

> It's difficult, but I am bound to look after them because there is no one else to look after them. Since they were born, [my daughter] hasn't looked after them. She used to move up and down with the boys. I was the one who took care of them. It's difficult to look after kids. Children need good care… These are my grandchildren. If they are hungry and ask for food, I buy it for them. If

> I don't give to them [what they need], my heart is painful. I see it better if I suffer with them.… (Anna, Other Death Household).

Many of our respondents were in similar situations, raising grandchildren belonging to their remarried, unemployed, or migrant children.

Other respondents, like Mumsy, take care of orphans. Mumsy cares for orphans who live in her household as well as orphans who live elsewhere. One of her daughters died in 1999 leaving three children. A son died more recently leaving four orphans for whom she helps care; in addition, she assists w45ith three of her sister-in-law's orphaned grandchildren.

> [My daughter] was staying [near Johannesburg] selling fruits, and vegetables; that's where she got these children. We don't know who the father of these children is. The children were staying [near Johannesburg] with their mother. Now their mother is dead. No one was going to look after them; that is the reason they came and stayed with me… I am [also] taking care of my grandchildren; the four who are not staying here. …. They are staying at their mother's family. Now my son and his wife both died… If they have problems, they come to me [and] I help them. I am also staying with my sister-in-law. She has three grandchildren. Their father died, no one is taking care of them. I use my pension money to help them (Mumsy, Other Death Household).

Mumsy feels stretched and worries a lot about making ends meet, "When my grandchildren come to me and ask for money, if I don't have any, I worry. Like now, one of my daughter's children is sick. No one is helping me to take care of her. One [grandchild] was not going to school because she didn't have shoes. [My grandchildren whose] father died don't get any money from the company where their father was working. If I think about all of this, I worry a lot" (Mumsy, Other Death Household). Mumsy takes care of more grandchildren than many of

our respondents, but both the feeling of being "bound" to take of the children and stretched thin financially resonates with most of our respondents' narratives.

The one way in which our respondents felt that they would be "rewarded" for their caregiving was through these children returning the assistance when the older woman needed it in the future and paying to bury her once she died. Sister did not see any disadvantage to taking care of orphaned or fostered children because, "The advantage is that they will grow up, work, and also support me when I will be too old, and also take care of me" (Sister, HIV/AIDS Household). Themba, who takes care of two grandchildren, said, "To take care of my grandchild is good because I know when I die my grandchild is going to bury me" (Themba, No Death Household). Regardless of whether these rewards ever come to fruition, in the present, our respondents saw taking care of their grandchildren as their responsibility. Several respondents, like Dorah who cares for two grandchildren, put this responsibility in the following terms, "I don't have any problem because I'm supporting my own blood" (Dorah, No Death Household).

DISCUSSION

Despite being less than 5% of the AHPU total population, it is clear from quantitative data that older women are dispersed over nearly a quarter of the households in the site. And, they are playing important roles in these households. The qualitative interviews point to the fact that older women are not just being supported by household members in the households in which they live, although sometimes working adult children send financial assistance or grandchildren as 'helpers' for their elderly mothers. Instead, these elderly women, who as a collective would usually be considered a "vulnerable population" themselves, in fact are taking care of other vulnerable household members—ill adult children, and fostered and orphaned grandchildren.

This paper begins to outline the roles that they play and their importance in sustaining the multi-generational households in which they live.

The older women in the households in our study were, as other literature has suggested, the primary caregivers to both HIV positive kin and AIDS orphans. Although our respondents spoke about rewards to caregiving, it was also clear from the interviews that there are emotional and financial drains related to this caregiving. This paper did not focus on deteriorations in elder women's health related to caregiving, but some of the narratives quoted above allude to the strains on mental and physical health that caregiving can entail. When prime-age adult deaths from HIV/AIDS or another cause, or are simply unemployed, their missing income has economic consequences for households where the elderly live. The elderly are left with the debts incurred from HIV/AIDS-related illnesses and funeral related expenses. In our sampled households, the elderly household member's pension made important contributions as a stable and reliable income. The pensions were in fact helping to diminish the impact of HIV/AIDS-related economic shocks, such as the cost of illness, funerals, and caring for orphans.

Although older women were taking care of kin in nearly all the households in our sample, it was clear that the responsibilities associated with caring for those sick with HIV/AIDS and the children left behind are great. Many of our respondents would hesitate to call these "burdens" because they are simply "taking care of their own blood;" however, this paper suggests that older women might be in need of further physical, emotional and financial support as the epidemic continues to bombard their community and they continue to be "bound" to take on such responsibilities.

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TABLES

Table I: Age-eligible Pensioners and Children in the AHDSS Site

	Individuals[1] (N=70,272)	Households[2] (N=11,665)
Women over 60	3.9% (2752)	22.2% (2671)
Men over 65	1.6% (1121)	9.5% (1112)
2+ pension age-eligible adults	N/A	5.4% (630)
1+ pension age-eligible woman **and** 1+ pension age-eligible man	N/A	4.8% (565)
Children <15 living in household with 1+ pension age-eligible individual(s)	26.3% (6766/25,727)[3]	26.4% (2391/9064)[3]
For households with both child(ren) <15 and age-eligible pensioner(s), child(ren) <15 who lived with pension age-eligible **woman**	84.4% (5708/6766)	85.2% (2036/2391)

[1] Percent and number of individuals in specified category
[2] Percent and number of households with members in specified category
[3] The 25,727 children <15 in the 2003 AHDSS lived in 9064 households, 2391 of which contained both child(ren) and age-eligible pensioner(s)

Table II: Mean household size			
	Household Size	Children in Household	Number of Households
Mean all households	6.02 (1-40)	2.21 (0-18)	11, 665
Mean with NO woman over 60	5.73 (1-30)	2.17 (0-17)	8,994
Mean with woman over 60	7.00 (1-40)[1]	2.31 (0-18)[2]	2,671
Mean with 2 or more age-eligible pensioners	6.91 (1-40) [1]	2.25 (0-18)	3,218

[1] Difference in mean size of households with and without a woman over 60 is statistically significant at the .001 level. The difference in mean household size with no elderly members and with two or more elderly members is also statistically significant at the .001 level.
[2] Difference between mean number of children in households with and without a woman over 60 is statistically significant at the p=.01 level.

Table III: Households with Children, Foster Children and Orphans			
	All Households	Households with NO woman 60+	Households with 60+ woman
Households with at least one child under 15	77.7%	77.8%	76.2%
Household with at least one foster child	15.4%	12.1%	26.5%[1]
Household with at least one maternal orphan	5.5%	4.7%	15.9%[1]
Total N	11,665	8,994	2,671

[1] Difference between households with and without a woman aged 60+ is significant at the p=.001 level

Table IV:Gogo Project Sample, Caregiving

	Took/taking care of ill adult child	Took/taking care of ill husband	Took/taking care of other ill kin
HIV/AIDS Households (N=10)	9	2	5
Other Death Households (N=10)	6	5	7
No Death Households (N=10)	7	3	8
Total (N=30)	22	10	20