The Changing role of older persons in the South African Households

Monde Makiwane, Human Sciences Research Council

A paper presented at the International Federation on Ageing, Copenhagen, Denmark.

30 May-2 June 2006

Abstract

The extended family used to be relied upon to provide subsistence and care for older persons in sub-Saharan Africa. However, recently South Africa has seen a reversal of roles, where older persons are now providing subsistence and care to younger generations. This role reversal started during the apartheid era as older persons took care of grandchildren and it is being accelerated by HIV/AIDS deaths among young adults. In most rural households, the non-contributory pension that is means-tested is an important factor in making older persons breadwinners. Using data from the 2004 Mpumalanga Older Persons Survey, we examined the changing role of older persons, which has been influenced mainly by changes in household structure and old age pensions. Preliminary findings show that in 63 percent of matrifocal multi-generational households, 76 percent of older persons are the sole providers of household necessities, care for the sick and grandchildren in increasingly skip-generation households.

---

*Correspondence concerning this article should be addressed to Sitawa R. Kimuna, Department of Sociology, East Carolina University, Greenville, NC 27858 [email: kimunas@mail.ecu.edu]. Authors' names are listed alphabetically.

The research reported in this article is part of the 2004 Mpumalanga Older Persons Survey (N=1002), which was conducted by the Human Sciences Research Council (HSRC), the MTD Development Company in conjunction with the Department of Health and Social Services, South Africa.

Introduction

The structure and function of families in most African societies are undergoing rapid transformations. Whereas in most African societies the older persons were absorbed into extended families and cared for, there has been a reversal in roles and now the older persons have taken on the role of caregiver to the younger generations. In South Africa, the older persons took on the care role during the apartheid era. The role reversal is being accelerated by HIV/AIDS deaths among young adults. The loss of young adults means not only the loss of the individuals, but the resources invested in them, which adversely affects the older persons. Another consequence of HIV/AIDS is an increase in the number of children who are orphaned.

According to UNAIDS (2004) sub-Saharan Africa accounts for as much as 80 percent of the world's orphans as a result of AIDS. Furthermore, orphaned children are more likely to live in households in which the head of the household is considerably older. Thus, older persons caring for grandchildren and other kin in countries severely affected by HIV/AIDS face hardship and are themselves in need of support. Yet, nowhere have the role and contribution of older persons in caring for orphaned grandchildren and other kin, nor in sustaining the integrity of the family structure and function been recognized or supported. Older persons' need for support to enhance their caregiving has been eclipsed by the attention given in policies and programs to the needs of HIV/AIDS orphans (HelpAge International (HAI), 2004).

Although in South Africa 60 percent of orphans live in grandparent-headed households (Monasch &Boerma, 2004), holistic policies that target families or the needs of family members including the older persons are lacking. Yet, grandparents' responsibility for orphans is increasing as the HIV/AIDS epidemic escalates. The responsibilities of caring for the younger generation places financial and physical burden on the older persons and further competes with

their personal needs. This study examines the changing roles and responsibilities of households headed by older persons in Mpumalanga, South Africa, specifically, factors that determine whether or not older people will give care to children below the age of six, children between the age of six and eighteen and sick children and adults.

Background

The population of older persons throughout the world is increasing at a high rate. The number of older persons aged 60 years and over is projected to reach 2 billion by 2050. In 2002 there were about 40 million people over 60 years in Africa and this number is projected to reach 103 million by 2050 (HAI, 2002). In South Africa, the proportion of older persons is projected to almost double in the next 30 years (2000-2030) from 7 percent to 12 percent. South Africa has shown a marked decline in fertility in the last few decades. In addition, the HIV/AIDS pandemic has contributed to the change in population structure, due to higher mortality of young adults, especially women of reproductive age. Furthermore, infant mortality rates have increased by nearly 20 percent (Legido-Quigley, 2003). Although the aging process is determined by declines in fertility accompanied by rapid declines in mortality, in Africa the number of older people is increasing despite the high mortality rates of young adults and the increasing infant mortality rates (Kimuna, 2000).

The rapid growth of population aging in Africa and the impact of HIV/AIDS add another dimension to the role of older persons and necessitate a closer look at understanding their needs. While traditionally the extended family took care of the younger and older generations, in South Africa older peoples' role of taking care of the younger generations started during the apartheid era as older people took care of grandchildren while their parents went to urban areas for employment as the law did not allow families to relocate to urban areas but the person employed.

Older women are increasingly heading households and caring for AIDS orphans (HAI, 2004; Agyarko et al.(WHO), 2004). However, their capacity is stretched due to lack of resources, breakdown of traditional support mechanisms, poor health and HIV/AIDS. Furthermore, cultural practices, which are still common in some parts of South Africa, are discriminatory to women. These practices include: the exclusion of women in family decision-making or limited in inheritance within the family. In some areas, older women are accused of witchcraft, which lead to their being stigmatized and ostracized from communities. Abuses of older women have been reported. Older women have experienced dehumanizing treatment at health clinics and pension pay points in South Africa.

Amid these problems, traditional household arrangements that accommodated the integration and care of older people are gone and in place, there are emerging new residential arrangements and roles for older people that include: older people who are breadwinners in multi generational households; older people who are in AIDS affected households. All these households headed by older people use meager social grants to support their households financially as well as care for adult members of their households who are terminally ill with AIDS. While the economic consequence of the older persons who give care to the sick and orphans or have lost children to HIV/AIDS is not quantifiable, its impact is remarkable. Care, medical treatment and funerals are costly, which further burdens older people. This burden is more evident in rural areas where accessibility to basic resources such as water, energy, food, and proper infrastructure is limited or non-existent. Furthermore, some households headed by older persons do not have access to any of the available government grants, which makes their situation more desperate.

The South African country position paper presented at the regional workshop on ageing and poverty organized by the United Nations Department of Economic and Social Affairs in Dar-es Salaam, 29-31 October 2003 reflected the status of poverty among older persons in South Africa. The paper defines poverty as the inability of individuals, households or entire communities to command sufficient resources to satisfy a socially acceptable minimum standard of living. Findings of the study showed that poverty levels in South Africa oscillate between 40 and 50 percent. The most affected are the very poor, who include African-headed households, female- headed households and rural households. Based on an analysis of the national datasets and the poverty line on monthly expenditure of Rand 800 (South African currency) per household, 25 percent of the population lives in households earning less than half the poverty line estimate of R800. Furthermore, as unemployment rate continues in the double digits, 40 percent and increasing, older peoples' pension funds, which are meant to meet some of their needs, now, serve as the main source of income for families.

In sub-Saharan Africa, South Africa, Namibia and Botswana are the only countries that have non-contributory social pension system. South Africa's pension scheme is means tested. To be eligible for the government pension, older women have to be over 60 years and older men have to be over 65 years. For the majority of households headed by older people in South Africa, the means-tested pension scheme is the main and often the only source of income. According to HelpAge International (2003), these monies that are meant to support older people are in fact spent mostly on school fees for school-going children living in the household and on food for the entire household. This paper examines the changing role of older persons, which has been influenced mainly by changes in household structure and old age pensions.

Major Hypotheses

The findings reported are based on 2004 Mpumalanga Older Persons Survey (N=1002). The association of care giving and non-contributory pension is examined. Specifically, we hypothesize that older people who are breadwinners through non-contributory pension are more likely to care for kin (the sick and children under age 18). We expect that households that are headed by non-contributory pensioners would be more likely to care for the kin. Female older people are more likely to care for kin. Studies have shown that households headed by older women are more likely to care for the sick and children (Ferreira, 2004; Hosegood & Ford, 2003; Monasch & Boerma, 2004). Also, we hypothesize that older people, who are in their later years (65-79 and 80+ years) would be less likely to care for kin. Older people in their later years have high morbidity and are themselves recipients of care. Thus, younger older persons 60-64 years would be more likely to provide care for members of their households. Age was categorized into three age groups (60-64 years, 65-79 years and 80+). Also, rural households are more likely to care for kin than urban households. Mpumalanga older peoples' households are predominantly rural, thus, we expect that these households will carry the burden of care. Furthermore, the old apartheid policies of South Africa prohibited natives to move to urban areas to live except for those with employment and even those with employment were to put up house only temporarily.

Method

Data and Sample Design

The 2004 Mpumalanga Older Persons Survey (N=1002), which was conducted by the Human Sciences Research Council (HSRC), the MTD Development Company in conjunction with the Department of Health and Social Services, South Africa is analysed. The sample was drawn from the 2001 census was used to determine the number of visiting points in an

enumeration area, which constitute residential stand, address, structure and flat in a block of flats or homestead. In the 2001 census, the enumeration area consisted of 100 to 200 visiting points. The sample was selected to be representative of the four types of areas in Mpumalanga, namely, urban formal, urban informal, rural formal and rural traditional (rural areas). The areas are defined as follows:

Urban formal is characterized by a well-established infrastructural planning. The area has basic services such as piped water, electricity, and sanitation. Formal planning in the area includes business centres, residential zones and in some urban formal areas, industrial zones.

Urban informal is an area found in urban cities but lacks the amenities of the urban formal. The area lacks basic services and is mostly not safe. The area can be likened to an urban slum; however, in South Africa the definition is not clear-cut because some urban informal settlements have basic services such as water and electricity. Nonetheless, the area has poor infrastructural planning and hence referred to as urban informal.

Rural formal is located in formal commercial farming areas. This type of settlement is managed and controlled by the commercial farmer. The population in this type of settlement is usually very small.

Rural traditional is a settlement that historically does not fall within the jurisdiction of any municipality. However, it have some form of a traditional authority such as elders or chiefs.

The following procedure was followed to select respondents for interview from the above areas: Visiting points within each enumeration area were chosen randomly and (i) if a visiting point had more than one household, only one household was randomly selected using a random selector grid. (ii) If there was more than one older person aged 60 and over in a household, only one older person was selected. (iii) Substitution of households randomly selected for interviews

was allowed only in the following situations: if a selected household was found to be empty; there was no eligible older person resident in the household; residents were not at home for an extended period of time; and/or there was serious physical danger posed to the lives of the interviewees. In addition, the substituted household had to have a fairly similar profile as the one to be substituted. For example, in an enumeration area with a mixture of formal and informal households, an informal household would not be substituted with a formal household.

The survey was designed to collect data on household composition including income, expenditure and household assets, education and employment, media access, health status and nutrition, services needed and received, care giving and receiving and experiences of older persons. The questionnaires were translated into the three main languages spoken in Mpumalanga, namely, *Sepedi, Siswati* and *Xitsonga.* The interviewers included trained staff from HSRC; the Department of Social Services, who were selected on the basis of previous experience and fluency in the above languages spoken in Mpumalanga. The general principles of ethics for social research were strictly adhered to in this study. The HSRC Research ethics committee approved the research. The fieldwork took four weeks to complete.

Descriptive Analysis

In this study, we use genealogical cohorts to define generation. The definition captures biological generations. However, the disadvantage of the definition is not considering other relationships within the households, such as adopted or foster family members. In South Africa and indeed in Mpumalanga, it is very difficult to differentiate between foster or adopted children from biological children. This is because foster or adopted families consider those children as their own biological children. In fact, in some instances grandparents may regard their grandchildren as their own children. In Mpumalanga, older persons head 75 percent of the

households. The mean age of older persons in Mpumalanga was 71.4 years (SD = 8.50). Of the 75 percent households, 60 percent of the households are located in predominantly rural traditional areas. Twenty four percent of the households are located in urban formal areas; 12 percent are located in rural formal and the remaining 5 percent are located in urban informal. Furthermore, the majority of older persons in Mpumalanga are widowed and reside in matrilocal, multigenerational households.

Slightly over 63 percent of the households are multigenerational households (see Table 1). Slightly more than 14 percent of the households are one-generation households and almost 23 percent of the households are skip-generation households. Thus, the majority of older persons' households in Mpumalanga have grandchildren and other kin co-residing with the older persons.

TABLE 1 ABOUT HERE

South Africa can be described as an "intermediate" country, whose population median age ranges from 22 for Black South Africans to 33 for White South Africans with an average age of 24 years (Udjo, 2004). In Mpumalanga, the median age is 27 years. Within these households, 25 percent of the people are under 14 years. There is a dependency ratio of 78, which means that for every person working in the working age group (aged 15-64 years), there are 78 dependents. Furthermore, when the sex ratio is computed for the Mpumalanga households, it is 38 older males per 100 older females. Generally, South Africa sex ratio is the lowest in the world, especially in rural areas. It is even more evident in the older persons due to high mortality among South African males. Studies of older people's households in South Africa have found a high proportion of older female-headed households (Ferreira et al., 2001; Ferreira & Brodrick, 2001; HAI, 2004; WHO, 2002). These households are among the poorest in every society and most of

them do not have access to regular income nor do they benefit from any type of old age grants.. Furthermore, the grants are insufficient to meet basic needs. Table 2 presents the distribution of the older persons in Mpumalanga compared with the national census distribution.

TABLE 2 ABOUT HERE

There are marked variations in older people's marital status. In Table 3, almost 17 percent of older women are currently married compared to 58 percent of older men. The high percentage of currently married reflects the general practice of men marrying younger women. In addition, an overwhelming majority of older women, who are widowed (71.1%), may reflect the high mortality rates among men in South Africa.

TABLE 3 ABOUT HERE

In assessing the wealth of older people's households using indicators such as possession of household goods and amenities, sources of income and expenditure patterns, data showed disparities by area. Households in urban formal areas have better resources than those households in formal rural (commercial farms). Furthermore, 81 percent of rural households receive government old age pension as compared to 74 percent of the urban households. Government old age pension is the main source of income for the majority of older people's households (77.2%). There is gender variation in old age pension in Mpumalanga. Old age pension is the main source of income for 81 percent of older female-headed households and for slightly more than 67 percent of older male-headed households. Whereas 2.2 percent of the households solely depend on gifts from family members as the main source of income, 52.4 percent of the households cite family contributions as the second main source of income. This indicates that family members supplement slightly more than half of Mpumalanga older persons' income.

Older persons are the breadwinners in 76 percent of the households. There are variations in generation type. Older persons are the main breadwinners in 70 percent of the multi-generation households with no significant differences between males and females. The overwhelming majority of the expenditures (97%) go to household necessities followed by water and electricity and children's education. It is interesting to note that specific needs of the older persons do not feature in the expenditures. Expenditure on electricity and water is high in urban formal and rural formal (35.2% and 36% respectively) than in urban informal and rural traditional (22% and 4% respectively).

Intergenerational Support in Mpumalanga

Data show that 75 percent of older people's households use their pension funds to support members of their households. On average, the number of people in these households ranges from 3 to 4 people with urban areas recording low numbers and rural areas registering high numbers. In addition, 9.1 percent of the older people's households provide care for HIV/AIDS terminally ill adults living in these households. Eighty five percent give care on a full time basis. Forty six percent of older persons provide full time care for children between the ages of 6 and 18 years. This care is mostly given by older females (51%) than older males (33%) and is confined within older people's households. Caring for children is prevalent in most residential types except in commercial farm areas (rural formal), where 27 percent report that they give such care.

Table 4 shows the unstandardized coefficients and their standard errors of three logistic regression models of care for children under age six (6), care for children between age six (6) and age 18 and care for the sick (children and adults) on age, gender and place of residence (rural traditional, urban informal and urban formal) and head of household as breadwinner. In Model 1 and Model 2, there was a significant net effect of age groups 60-64 on caring for children under

the age of six ($p<.05$) and caring for children between age six and age eighteen ($p<.01$). Also the analysis showed that age group 65-79 was significantly more likely to care for children under the age of six ($p<.01$) and children between the age of six and eighteen years ($p<.01$) than age group 80 and over. The hypothesis that older people in age group 65-79 are less likely to be caregivers was not supported. Nonetheless, it is not surprising since research has shown that orphaned children are more likely to live in households that have much older people.

Also, Table 3, Model 2 shows that older women in Mpumalanga are significantly ($p<.01$) more likely to care for children under the age of 18 years. This finding is similar to Monasch and Boerma (2004) study on orphanhood and childcare patterns in sub-Saharan Africa. Female-headed households are more likely to have orphans living in them and these households have considerably older people caring for large numbers of HIV/AIDS orphans. Yet, they are more likely to be widowed, to live in poverty and to be infirm than men. Older women's precarious position is more exacerbated by traditional practices that dictate issues to do with inheritance, ownership of property, economic status and so forth. In addition, HIV/AIDS has further complicated their situation as they continue in their traditional roles as care givers of the sick in the family and later become surrogate parents to HIV/AIDS orphans. They are carrying out the added responsibilities at the cost of their own health and well being and at high cost to their own livelihoods.

It is surprising to note that older people with completed secondary education are significantly ($p<.05$) less likely to care for children under the age of eighteen. Educated older people know the importance of education and they would, therefore, provide quality care including the education of HIV/AIDS orphans. HIV/AIDS is an obstacle to orphaned children particularly girls achieving an education. Older people who have completed secondary school

would provide encouragement, as well as psychological support for the orphans. Also, they would provide community education that could in the long run eliminate HIV/AIDS stigma and bring about policies to counter discrimination.

It was expected that households headed by non-contributory pensioners would be more likely to be caregivers. This study found that older people who are heads of households and are breadwinners are significantly ($p<.05$) more likely to care for children under the age of eighteen (see Table 4, Model 1 and Model 2). This finding supports our hypothesis that older people who are breadwinners through non-contributory pension are more likely to care for children under age 18. Although this finding supports the above hypothesis, Model 3 (caring for the sick children and adults) is not supported. It might be that head of household status as well as being a breadwinner provides older people power to delegate some of the care giving chores to other members of the household especially if they are male heads of households.

Living in rural areas significantly increases the likelihood of care giving. Results show that older people's households in rural traditional are significantly ($p<.01$) more likely to provide care for children under the age of 18 (See Table 4, Model 1 and Model 2). Older people's households are predominantly rural traditional. In addition, these rural households are likely to care for children because young adults leave rural areas for cities in search of employment and leave their children with grandparents. Furthermore, there is the added burden of taking in grandchildren, whose parents have died of HIV/AIDS. Although these findings support the hypothesis that older people's households in rural traditional bear the heaviest burden of care giving, findings in this study also show that older people living in urban formal households are significantly ($p<.05$) more likely to care for children under the age of six and also significantly ($p<.01$) more likely to care for children between the age of six and the age of eighteen. These

findings reflect the changing roles of caregiving in sub-Saharan Africa regardless of place of residence.

In Model 3, caring for sick children and adults was not significantly related to any of the independent variables. This finding is of interest because in the descriptive analysis, 9.1 percent of the older people's households provide care for HIV/AIDS terminally ill adults living in these households. Furthermore, studies have highlighted the vulnerability of older people as care givers of HIV/AIDS orphans and sick adults (Ferreira, 2001; HAI, 2003; UN, 2004). Our finding that older people's households do not care for sick children and adults may be because those that are terminally ill these households have died.

Discussion and Conclusion

The findings in this study indicate that non-contributory pensions, although aimed at improving the well-being of the older people, they have a dual purpose; they support pensioners and their households. Non-contributory pension benefits play a substantial role in sustaining older people's households. In Mpumalanga, older people share their non-contributory pension with other members of their households and consequently, the pension benefit is the main income supporting members in these households. Recent debates on social protection in South Africa have focused on the effectiveness of the social assistance programs in reducing poverty and vulnerability (Barrientos, 2003). The argument has been made that changes in the pattern of risk affecting the population vulnerability, especially the impact of HIV/AIDS calls for policies that focus on social assistance programs. Thus, non-contributory pensions are perceived as extremely beneficial in addressing the rising household vulnerability and providing older people with little money to invest in income-generating activities and the health and education of members of their households.

Furthermore, households headed by female older people are more likely to provide care. As shown in this study, older women predominantly do care giving. The majority of these older women are widows, who had not inherited anything from their husbands or the parents of the orphaned grandchildren under their care. These households lack the resources needed to sustain a family. Although their non-contributory pension does provide minimum support, the means tested benefit is shared by members of the households and in most cases most of it goes toward health care of the sick and education of the orphaned grandchildren. Yet, there have been reports about the abuse of older people at the payment services stations. Such abuses have included older people dying in pension queues. Furthermore, the pension payout institution provides non-contributory pensioners micro lending services at exorbitant interest rates (Mail & Guardian, 2003).

Rural traditional and urban formal both bear the burden of care giving. These findings underscore that older people in urban areas might have moved into their children's households to take care of their ailing children and after their children's death, they remained to care for their orphaned grandchildren. In addition, orphaned grandchildren, who lived in urban formal areas and lost both parents, are sent to the rural traditional areas to be cared for by their grandparents.

Surprisingly, older people with completed secondary education are less likely to be caregivers to children under the age of 18. Older people with completed secondary education should be targeted with strategies that encourage them to participate in care giving. Their contributions are critical as educated older people would be a great asset since they can be strong advocates for policies that are beneficial to both the young and the old. Nonetheless, older people are taking on the role of caregiver and surrogate parent and yet, their contributions have been

generally ignored. They support their terminally ill children and their orphaned grandchildren in poverty, and often in poor health.

In sum, this study has shown that older people in Mpumalanga are a resource. As breadwinners in their households, they provide the basic necessities including health care and education for the members of their households using their meagre non-contributory, means tested pension funds. The care giving role is mostly relegated to older people who are female with no resources. The majority of older people live in rural traditional areas, where there is lack of basic amenities. Thus, governments should address factors that impede the successful care giving role of older people. Because HIV/AIDS epidemic affects families and intergenerational relations, as well as generational interdependency, policies that strengthen affected families' capacity and enhance the well being of these families should be implemented. These policies should include improved security at pension service stations; improved intergenerational family communication policies and programs that address HIV/AIDS-related issues. In addition, governments should support the care giving roles of older people by providing better medical care services to older people. Healthier older people would effectively perform care-giving roles.

References

Agyarko, R.D.; Madzingira, N.; Mupedziswa, R.; Mujuru, N.; and Kanyowa, L. (2002) Impact of AIDS on older people in Africa: Zimbabwe case study. World Health Organization. Geneva.

Barrientos, A. (2003). Non-contributory pensions and poverty prevention: A comparative study of Brazil and South Africa. IDPM and HelpAge International.

Ferreira, M. (2004). Older caregivers in African households affected by HIV/AIDS: supporting the caregivers and promoting family well-being. Paper presented at the African Conference on Ageing: Rapid ageing and the changing role of the elderly in African households. 18-20 August, 2004. Johannesburg, South Africa.

Ferreira, M.; Keikelame, M. J. & Mosaval, Y. (2001). Older women as carers to children and grandchildren affected by AIDS: A study towards supporting the carers. Institute of Ageing in Africa. University of Capetown. Cape Town, South Africa.

Formatted: Portuguese (Brazil)

Ferreira, M. & Brodrick, K. (2001). Towards supporting older women as carers to children and grandchildren affected by AIDS: A pilot intervention project. Institute of Ageing in Africa. University of Cape Town. Cape Town, South Africa.

HelpAge International. (2004). Grandparents' growing role as carers. Briefing. Ageing and Development, 16 (June): 6-8.

HelpAge International. (2003). Forgotten families: Older people as carers of orphans and vulnerable children. International HIV/AIDS Alliance/HelpAge International.

HelpAge International. (2002). State of the world's older people, 2002. HelpAge International, London.

Hosegood, V & Ford, K. (2003). The Impact of HIV/AIDS on children's living arrangements and migration in rural South Africa. Paper presented at the African Migration in Comparative Perspective. Johannesburg, South Africa, 4-7 June 2003.

Kimuna, S. R. (2000). Population ageing: Unravelling challenges of socio-economic support for elderly Zimbabweans. Ph.D. unpublished dissertation. Kansas State University.

Legido-Quigley, H. (2003). The South African old age pension: Exploring the role on poverty alleviation in households affected by HIV/AIDS. Paper presented at the 4th International Research Conference on Social Security, 5-7 May. Antwerp. [online] http://www.issa.int/

Mail and Guardian. (July 4-10, 2003). Page 4.

Monasch, R. & Boerma, J. T. (2004). Orphaned and childcare patterns in sub-Saharan Africa: an analysis of national surveys from 40 countries. *AIDS*, 18(Suppl. 2): S55-S65.

Udjo, E. O. (2004). Demographic impact of HIV/AIDS on ageing on South Africa's population. Paper presented at the African Conference on Ageing: Rapid ageing and the changing role of the elderly in African households. 18-20 August, 2004. Johannesburg, South Africa.

UNAIDS. (2004). Report on the global AIDS epidemic. Joint United Nations Program on HIV/AIDS (UNAIDS). Geneva.

United Nations. (2004). The impact of AIDS. United Nations Population Division. New York.

Formatted: Portuguese (Brazil)

Table 1: Generation Type of Older Persons Households

Household Type	Frequency	Percent
One generation households	131	14.3
Two or more generation households	577	63.1
Skip generation households	206	22.6
Total	914	100

Table 2: Distribution of the older persons in Mpumalanga (MOPS*, 2004) compared to the national distribution (Census 2001).

Age Group	MOPS* N=1002	Percent (MOPS*)	Percent (Census 2001)
60-64	255	25.5	32.3
65-69	219	21.8	22.1
70-74	209	20.9	20.0
75-79	136	13.6	10.7
80-84	79	7.9	9.4
85+	104	8.7	5.4

*2004 Mpumalanga Older Persons Survey (MOPS)

Table 3: Marital Status of Mpumalanga Older Persons by Gender

Marital Status	Male		Female	
	Frequency	**Percent**	**Frequency**	**Percent**
Currently Married	159	58.0	121	17.0
Living together	13	4.7	4	0.6
Divorced	17	6.2	44	6.1
Widowed	72	26.4	512	71.1
Never Married	13	4.7	39	5.2
Total	274	100	720	100

Table 4: Logistic Regression Results Predicting the Likelihood of Caring for Children under age 6, Caring for Children between age 6 and 18 and Caring for the Sick (Children and Adults) N = 1002[a]

Characteristics	Model 1 Under age 6	Model 2 Age 6 - 18	Model 3 Sick (children & adults)
Age			
60-64	0.856* (0.352)	0.754** (0.246)	-0.404 (0.394)
65-79	1.063** (0.319)	0.632** (0.219)	-0.407 (0.338)
Gender			
Female	0.128 (0.555)	0.631** (0.172)	-0.521 (1.104)
Education?			
None & incomplete Primary	-0.286 (0.861)	-1.813 (1.093)	-0.521 (1.104)
Complete Primary	-0.953 (0.895)	-1.926 (1.104)	-0.750 (1.145)
Complete Secondary +	-0.953 (0.926)	-2.247* (1.119)	-1.672 (1.307)
Head of household			
Breadwinner	0.439* (0.232)	0.345* (0.177)	0.006 (0.312)
Place of residence			
Urban formal	1.081* (0.477)	0.778** (0.290)	0.484 (0.507)
Urban informal	0.927 (0.696)	0.756 (0.449)	0.930 (0.702)
Rural traditional	1.655** (0.444)	0.953** (0.264)	0.361 (0.468)
Constant	-3.624 (1.035)	-0.359 (0.177)	-1.642 (1.255)
-2 Log-Likelihood	741.438	1024.032	439.605
Number of cases	621	779	780

*p<.05; **p<.01; ***p<.001

[a]Unstandardized regression coefficients with standard errors in parentheses